

6872

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ralls Nursing Home				d. STREET ADDRESS 1412 Delafield Pl, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle L Last Alley				4. DATE OF DEATH Month June Day 9 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Dailey				14. MOTHER'S MAIDEN NAME Jane Albritton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO Genl Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs (c)				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Chronic Pulmonary Tuberculosis - healed			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 22, 1959 , to June 9, 1959 , that I last saw the deceased alive on June 8, 1959 , and that death occurred at 9:30 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED 1714 R I Ave NW Wash DC 6/9/59			
ACTUAL SIGNATURE Arthur H. Lewis				M.D. 1714 R I Ave NW Wash DC			
PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 June '59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS 300 4th St. N. E.		24a. REC'D BY REGISTRAR JUN 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur H. Lewis							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6901

CERTIFICATE OF DEATH

06864

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY Tampa c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48X-3 d. STREET ADDRESS 8503 Twin Lakes Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edgar Marshall Andrews, Jr.				4. DATE OF DEATH Month Day Year June 8, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 16, 1924	
9. AGE (In years lost birthday) yrs. 34		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Paper Company		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edgar M. Andrews, Sr.		14. MOTHER'S MAIDEN NAME Ebba Lundin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Midline Lethal Granuloma 138.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1959 , to June 8, 1959 , that I last saw the deceased alive on June 8, 1959 , and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-8-59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE James C. Kirby, Jr. PHYSICIAN'S NAME (Type) James C. Kirby, M.D.		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF Jne. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY Tampa Cem.		22d. LOCATION (City, town, or county) (State) Tampa, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6902 Item 9 Film G244 6-30-59 et
CERTIFICATE OF DEATH

06865

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) Bethesda		c. LENGTH OF STAY IN 1b 49 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas		83 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 560 Centreville Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle (n) Last ARNOTT		4. DATE OF DEATH Month June Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 October 1898
9. AGE (In years last birthday) yrs. 60 6/7		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Americal Supply Co.	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert ARNOTT		14. MOTHER'S MAIDEN NAME Janet THOMSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I WW II		16. SOCIAL SECURITY NO. UNKNOWN	
INFORMANT Mrs. Josephine ARNOTT		560 Centreville Rd. Manassas, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Generalized Carcinomatosis DUE TO (b) (Adenocarcinoma, stomach with widespread metastases) DUE TO (c) (to liver, bone, lung) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-2 , 19 59 , to 6-20 , 19 59 , that I last saw the deceased alive on 6-20 , 19 59 , and that death occurred at 2320P M, from the causes and on the date stated above. F. H. O'Connell Lt. MC USN ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL BETHESDA MD DATE SIGNED 6/21/59			
ACTUAL SIGNATURE F. H. O'CONNELL LT MC USN		M.D. U.S. NAVAL HOSPITAL BETHESDA MD	
PHYSICIAN'S NAME (Type) F. H. O'CONNELL LT MC USN		U.S. NAVAL HOSPITAL BETHESDA MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS		ADDRESS 517 11th St. S.E. Wash. D.C.	
24a. REC'D BY REGISTRAR JUN 23 59		24b. REGISTRAR'S SIGNATURE Arthur J. Frank	

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06866

6903

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle August Last Aue		4. DATE OF DEATH Month June Day 26 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/91
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 26 Hours 19 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred L. Aue		14. MOTHER'S MAIDEN NAME Marie Freund	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-07-7384	
17. INFORMANT Home Records- Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163x IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PORTAL CIRRHOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 51 , to June 26 , 19 59 , that I last saw the deceased alive on June 26 , 19 59 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5910 Cambridge Ave. Cerebro. 6x-8 DATE SIGNED ACTUAL SIGNATURE Stanley W. Kinstein M.D. PHYSICIAN'S NAME (Type) STANLEY W. KINSTEIN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/29/59	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR JUN 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24c. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 1 yr.		d. STREET ADDRESS 7203 Denton Rd.,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle S. Last BABB		4. DATE OF DEATH Month June Day 26, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Arnold Scherr		14. MOTHER'S MAIDEN NAME Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		DATE SIGNED June 26, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-29-59		22b. DATE THEREOF 6-29-59	
22c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		22d. LOCATION (City, town, or county) (State) Keyser, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR JUL 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MEDICAL CERTIFICATION

2

STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE		COUNTY OF BALTIMORE CITY OF BALTIMORE	
NAME OF DECEASED Kenneth Edgar Johnson		RESIDENCE 7302 Landon Rd.	
DATE OF DEATH June 26, 1954		PLACE OF DEATH Home	
TIME OF DEATH 10:30 AM		AGE 35	
SEX Male		RACE White	
OCCUPATION None		MARITAL STATUS Single	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
MEDICAL HISTORY None		SOCIAL HISTORY None	
PHYSICAL EXAMINATION None		LABORATORY EXAMINATIONS None	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF WITNESS [Signature]	
DATE June 26, 1954		PLACE Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06868

6905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 3024 Rodman St. N.W.	
3. NAME OF DECEASED (Type or print) ALFRED N. BAILEY		4. DATE OF DEATH Month June Day 19 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1873
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 13 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming House Operator - self		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Seth Bailey		14. MOTHER'S MAIDEN NAME FLORA MARSHALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Louise Bailey - 3024 Rodman St. N.W.		Address Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Sudden Death - 2 days DUE TO Congestive Heart Failure - 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) yes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 6 Day 19 Year 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18/59 , 19 59 , to 6/19/59 , 19 59 , that I last saw the deceased alive on 6/18/59 , 19 59 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE SAM ALLEN, M.D.		ADDRESS (Street, city or town, state) Kensington, Maryland	
PHYSICIAN'S NAME (Type) SAM ALLEN, M.D.		DATE SIGNED 6/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/21/59	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) White Cloud, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6906 CERTIFICATE OF DEATH

06869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alta Vista Rest Home		d. STREET ADDRESS 4814 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) Georgia		4. DATE OF DEATH Month June Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1868
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR: Months 4 Days 5 IF UNDER 24 HRS.: Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Robbins		14. MOTHER'S MAIDEN NAME Mary Moody	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lillian Rankin - Item#2-daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ventricular Fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 30 min Undetermined Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Generalized Arteriosclerosis Cerebrovascular Hemorrhage Chronic Nephritis & Uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1954 to June 21, 1959 , that I last saw the deceased alive on May 13, 1959 , and that death occurred at 6:08 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave DATE SIGNED June 21 1959 ACTUAL SIGNATURE George L Ball M.D. PHYSICIAN'S NAME (Type) George L Ball Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 23 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

CORONER NOTIFIED AND WILL APPROVE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6873

Item 12 Film 6243 6-11-59 et

CERTIFICATE OF DEATH

Item 22 Film 6243 6-15-59 et

06870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Soosey</u> Middle <u>—</u> Last <u>Bargad</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-75</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Bargad</u>		14. MOTHER'S MAIDEN NAME <u>Eida Coca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Washington San. & Hosp. Records - Takoma Park Maryland</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Semility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1949</u> to <u>June 8, 1959</u> , that I last saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>7:22 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erwin Steinman M.D.</u>		ADDRESS (Street, city or town, state) <u>3500-14th ST. NW</u>	
PHYSICIAN'S NAME (Type) <u>ERWIN STEINMAN M.D.</u>		DATE SIGNED <u>June 8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyaneky</u>		ADDRESS <u>3500-14th ST. NW</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

100-200

100-200

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>10-15-1925</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>7. MARITAL STATUS</p> <p><i>Married</i></p>		<p>8. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>	
<p>9. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>10. DATE OF DEATH</p> <p><i>10-20-1970</i></p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p><i>Dr. J. Smith</i></p>		<p>12. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	

6907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General				e. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Ewing Last Beall		4. DATE OF DEATH Month 6 Day 27 Year 19 59		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4.20.1889		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas W. Beall				14. MOTHER'S MAIDEN NAME Mary Frances Burdette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Lucille B. Smith Address Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) diabetes mellitus DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple coronary occlusions DUE TO (c) Cerebral vascular accident, gen. art. scler., diabetic gangrene						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident, gen. art. scler., diabetic gangrene						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 19 o. m. 0 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Damascus, Md.		20g. (County) Damascus		20h. (State) Md.	
21. I certify that I attended the deceased from Aug. 20, 1958 , to June 27, 1959 , that I last saw the deceased alive on June 26, 1959 , and that death occurred at 3:57 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. F. Meadors		M.D. G. F. Meadors, M.D.		ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED JUN 30 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Purdim, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR Arthur L. Farris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10811

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

6903

Page One of Two

NAME OF DECEASED Thomas F. Hall		AGE 65		SEX Male		RACE White		DATE OF DEATH April 20, 1955		PLACE OF DEATH Home	
RESIDENCE 1015 North Howard Street, Baltimore, Md.		OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF BIRTH April 25, 1890		PLACE OF BIRTH Baltimore, Md.		MOTHER'S NAME Mary Elizabeth Hall		FATHER'S NAME John F. Hall		PREVIOUS ILLNESS None		HISTORY OF PRESENT ILLNESS None	
DATE OF INTERVIEW April 25, 1955		INTERVIEWED BY J. B. Smith		DATE OF DEATH April 20, 1955		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF INTERVIEW April 25, 1955		INTERVIEWED BY J. B. Smith		DATE OF DEATH April 20, 1955		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	

6908

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06872

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>12328 Collesville Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12328 Collesville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Vincent Bear Sr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1908</u>
9. AGE (in years and birth day) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas J. Bear</u>		14. MOTHER'S MAIDEN NAME <u>Helen Craft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-18-6829</u>	
17. INFORMANT <u>Joseph T. Bear</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on home floor</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 4 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06873

24b. REGISTRAR'S SIGNATURE
William S. Krane

VS A15 (4)
15M 10/57

6910

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>		e. STREET ADDRESS <u>1514 Emerson St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>May</u> Middle <u>Bendall</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <u>5-4-1876</u>
8. AGE (In years last birthday) <u>83</u> yrs.		9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School-teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Thomas Bendall</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Stone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Asbury Methodist Home - Gaithersburg</u> Address <u>MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-28</u> 19 <u>55</u> , to <u>JUNE 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 28</u> , 19 <u>59</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/28 CEDAR LAKE NEWING TOWN, MD 6-30-59</u>	
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Warrenton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Warrenton Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albion</u> ADDRESS <u>316 E Diamond Ave Gaithersburg, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1912
CERTIFICATE OF DEATH

ANALYST
EXAMINER
INVESTIGATOR

NAME
RESIDENCE
AGE
SEX
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
OFFICIAL USE

1. Name of deceased
2. Residence
3. Age
4. Sex
5. Occupation
6. Cause of death
7. Place of death
8. Date of death
9. Time of death
10. Signature of physician
11. Signature of registrar
12. Official use

13. Date of death
14. Time of death
15. Signature of physician
16. Signature of registrar
17. Official use

6911 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-8 d. STREET ADDRESS 2407 North Roosevelt Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Margaret (n) BENTLEY			4. DATE OF DEATH Month Day Year June 12 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 April 1872	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John MEIKLE			14. MOTHER'S MAIDEN NAME Elizabeth PENANT		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT (Daughter) Edith M. GORDANIER		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma pancreas DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 13 days unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive jaundice					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Spokane, Washington	(County) (State)	
21. I certify that I attended the deceased from 22 May , 19 59 , to 12 June , 19 59 , that I last saw the deceased alive on 12 June , 19 59 , and that death occurred at 06:15 AM from the causes and on the date stated above.					
ACTUAL SIGNATURE W.D. Hooper		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) W.D. HOOPER LT MC USN		U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment 6-14-59	22b. DATE THEREOF 6-14-59	22c. NAME OF CEMETERY OR CREMATORY Riverside	22d. LOCATION (City, town, or county) (State) Spokane, Washington		
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

1

051

1

2

VS A15 (4)
ISM 9/58

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6874

CERTIFICATE OF DEATH

06876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Conv. Home 517 Albany Ave</u>				d. STREET ADDRESS <u>202 Van Buren St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Katherine Brittain Blackwood</u>				4. DATE OF DEATH <u>June 1 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Brittain</u>				14. MOTHER'S MAIDEN NAME <u>Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Ann L. Sotem</u> Address <u>202 Van Buren Wash. D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Semipity</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1, 1959</u> , to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>June 1, 1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip E Jones</u>				ADDRESS (Street, city or town, state) <u>918 Plover Dr. Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>Philip E Jones</u>				DATE SIGNED <u>June 3 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Kirk Co 2901-14th St N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirk</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kenwood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5804-Brookside Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Devereux</u> Last <u>Blair</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1956</u>		9. AGE (In years last birthday) <u>2 yrs.</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clay Drewry Blair</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Kemp Devereux</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Patricia Devereux Aunt</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRAUMATIC SHOCK</u> DUE TO <u>LACERATIONS OF LIVER AND SPLEEN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>AUTOMOBILE ACCIDENT</u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walked on street in front of approaching car</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:15 p.m. 6/19/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Kenwood n Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				DATE SIGNED <u>6/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 13, 14 Film G244 7-14-59 et

6913

CERTIFICATE OF DEATH

06878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>9609-Bull Run Parkway</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Elie A. Borda</i>		4. DATE OF DEATH Month Day Year <i>June 30 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 29, 1894</i>
9. AGE (In years last birthday) <i>65 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min. <i>4 20</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Composer of music</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- - - - -</i>	
11. BIRTHPLACE (State or foreign country) <i>France</i>		12. CITIZEN OF WHAT COUNTRY? <i>France</i> ✓	
13. FATHER'S NAME <i>Unknown Alfred Borda</i>		14. MOTHER'S MAIDEN NAME <i>Unknown Gracianne Mainard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Gabriel P. Borsky</i> Address <i>9609 Bull Run Parkway</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X INFARCTION OF BRAIN STEM</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>BASILAR ARTERY OCCLUSION</i> (c) <i>CEREBRO-VASCULAR ARTERIO-SCLEROSIS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 DAYS</i> <i>OVER 4 YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CORONARY ARTERY DISEASE-OLD MYOCARDIAL INFARCT</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 16, 1959</i> to <i>June 30, 1959</i> that I last saw the deceased alive on <i>June 29, 1959</i> and that death occurred at <i>9:50 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph D. Connor</i> M.D.		ADDRESS (Street, city or town, state) <i>9420 Old Georgetown</i> DATE SIGNED <i>June 30, 1959</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH D. CONNOR, MD</i>		<i>Bethesda, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-2-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		22d. LOCATION (City, town, or county) (State) <i>Silver Spring, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>JUL 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

Robert A. [illegible]
[illegible]
[illegible]

6914

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Co.</u> b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b _____		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Vincent Berger</u>			4. DATE OF DEATH Month Day Year <u>June 21 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6 1912</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing Dist. of Co.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Berger</u>			14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		INFORMANT Address <u>Beatrice C. Berger - same wife.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>HYPERTENSION</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS</u> <u>10 YRS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>59</u> , to <u>June 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>59</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo I Donovano M.D.</u>		ADDRESS (Street, city or town, state) <u>5016 Georgetown Rd. Bethesda 14 Md</u> DATE SIGNED <u>6/21/59</u>			
PHYSICIAN'S NAME (Type) <u>LEO I DONOVANO M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	
22d. LOCATION (City, town, or county) <u>Washington D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heens Funeral Home</u>		ADDRESS <u>3605-14 St</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u> DATE <u>JUN 23 '59</u>	
24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
SAN FRANCISCO, CALIF.

1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6915

CERTIFICATE OF DEATH

Reg. Dist. No.

06880

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
f. STREET ADDRESS 4000 Cathedral Ave. NW		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fanny P. Bowersock		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Oct. 1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unkown) Pickering		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. None	
17. INFORMANT J. L. Sheldon		Address 730 15 th. St. Wash. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia, chronic 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary atherosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1958 , to June 30, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 929 Preshing Dr., Silver Spring Md. DATE SIGNED 30 Jun 59			
ACTUAL SIGNATURE Seruch T. Kimble		M.D. 929 Preshing Dr., Silver Spring Md.	
PHYSICIAN'S NAME (Type) Seruch T. Kimble, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 1st. 1959	
22c. NAME OF CEMETERY OR CREMATORY Lees Crematorium		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300 4th St NE Wash DC	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

100-10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1915

100-10000

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE REGISTRAR	
1. NAME OF DECEASED J. E. GARDNER		2. SEX Male	
3. AGE 70		4. RACE White	
5. DATE OF DEATH Oct. 9, 1915		6. TIME OF DEATH 10:30 A.M.	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF REGISTRAR J. E. Gardner		12. SIGNATURE OF DECEASED J. E. Gardner	
13. SIGNATURE OF WITNESS J. E. Gardner		14. SIGNATURE OF WITNESS J. E. Gardner	
15. SIGNATURE OF WITNESS J. E. Gardner		16. SIGNATURE OF WITNESS J. E. Gardner	
17. SIGNATURE OF WITNESS J. E. Gardner		18. SIGNATURE OF WITNESS J. E. Gardner	
19. SIGNATURE OF WITNESS J. E. Gardner		20. SIGNATURE OF WITNESS J. E. Gardner	
21. SIGNATURE OF WITNESS J. E. Gardner		22. SIGNATURE OF WITNESS J. E. Gardner	
23. SIGNATURE OF WITNESS J. E. Gardner		24. SIGNATURE OF WITNESS J. E. Gardner	
25. SIGNATURE OF WITNESS J. E. Gardner		26. SIGNATURE OF WITNESS J. E. Gardner	
27. SIGNATURE OF WITNESS J. E. Gardner		28. SIGNATURE OF WITNESS J. E. Gardner	
29. SIGNATURE OF WITNESS J. E. Gardner		30. SIGNATURE OF WITNESS J. E. Gardner	
31. SIGNATURE OF WITNESS J. E. Gardner		32. SIGNATURE OF WITNESS J. E. Gardner	
33. SIGNATURE OF WITNESS J. E. Gardner		34. SIGNATURE OF WITNESS J. E. Gardner	
35. SIGNATURE OF WITNESS J. E. Gardner		36. SIGNATURE OF WITNESS J. E. Gardner	
37. SIGNATURE OF WITNESS J. E. Gardner		38. SIGNATURE OF WITNESS J. E. Gardner	
39. SIGNATURE OF WITNESS J. E. Gardner		40. SIGNATURE OF WITNESS J. E. Gardner	
41. SIGNATURE OF WITNESS J. E. Gardner		42. SIGNATURE OF WITNESS J. E. Gardner	
43. SIGNATURE OF WITNESS J. E. Gardner		44. SIGNATURE OF WITNESS J. E. Gardner	
45. SIGNATURE OF WITNESS J. E. Gardner		46. SIGNATURE OF WITNESS J. E. Gardner	
47. SIGNATURE OF WITNESS J. E. Gardner		48. SIGNATURE OF WITNESS J. E. Gardner	
49. SIGNATURE OF WITNESS J. E. Gardner		50. SIGNATURE OF WITNESS J. E. Gardner	
51. SIGNATURE OF WITNESS J. E. Gardner		52. SIGNATURE OF WITNESS J. E. Gardner	
53. SIGNATURE OF WITNESS J. E. Gardner		54. SIGNATURE OF WITNESS J. E. Gardner	
55. SIGNATURE OF WITNESS J. E. Gardner		56. SIGNATURE OF WITNESS J. E. Gardner	
57. SIGNATURE OF WITNESS J. E. Gardner		58. SIGNATURE OF WITNESS J. E. Gardner	
59. SIGNATURE OF WITNESS J. E. Gardner		60. SIGNATURE OF WITNESS J. E. Gardner	
61. SIGNATURE OF WITNESS J. E. Gardner		62. SIGNATURE OF WITNESS J. E. Gardner	
63. SIGNATURE OF WITNESS J. E. Gardner		64. SIGNATURE OF WITNESS J. E. Gardner	
65. SIGNATURE OF WITNESS J. E. Gardner		66. SIGNATURE OF WITNESS J. E. Gardner	
67. SIGNATURE OF WITNESS J. E. Gardner		68. SIGNATURE OF WITNESS J. E. Gardner	
69. SIGNATURE OF WITNESS J. E. Gardner		70. SIGNATURE OF WITNESS J. E. Gardner	
71. SIGNATURE OF WITNESS J. E. Gardner		72. SIGNATURE OF WITNESS J. E. Gardner	
73. SIGNATURE OF WITNESS J. E. Gardner		74. SIGNATURE OF WITNESS J. E. Gardner	
75. SIGNATURE OF WITNESS J. E. Gardner		76. SIGNATURE OF WITNESS J. E. Gardner	
77. SIGNATURE OF WITNESS J. E. Gardner		78. SIGNATURE OF WITNESS J. E. Gardner	
79. SIGNATURE OF WITNESS J. E. Gardner		80. SIGNATURE OF WITNESS J. E. Gardner	
81. SIGNATURE OF WITNESS J. E. Gardner		82. SIGNATURE OF WITNESS J. E. Gardner	
83. SIGNATURE OF WITNESS J. E. Gardner		84. SIGNATURE OF WITNESS J. E. Gardner	
85. SIGNATURE OF WITNESS J. E. Gardner		86. SIGNATURE OF WITNESS J. E. Gardner	
87. SIGNATURE OF WITNESS J. E. Gardner		88. SIGNATURE OF WITNESS J. E. Gardner	
89. SIGNATURE OF WITNESS J. E. Gardner		90. SIGNATURE OF WITNESS J. E. Gardner	
91. SIGNATURE OF WITNESS J. E. Gardner		92. SIGNATURE OF WITNESS J. E. Gardner	
93. SIGNATURE OF WITNESS J. E. Gardner		94. SIGNATURE OF WITNESS J. E. Gardner	
95. SIGNATURE OF WITNESS J. E. Gardner		96. SIGNATURE OF WITNESS J. E. Gardner	
97. SIGNATURE OF WITNESS J. E. Gardner		98. SIGNATURE OF WITNESS J. E. Gardner	
99. SIGNATURE OF WITNESS J. E. Gardner		100. SIGNATURE OF WITNESS J. E. Gardner	

6916 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4204 Stanford Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN MAY MOORE		4. DATE OF DEATH Month Day Year 6 17 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1874
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months 3 Days 6 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William K. Bowman		14. MOTHER'S MAIDEN NAME Ida Creamer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Bowman H Moore-son-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Colostomy after Removal of Ca Rectum 1946		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1946 to June 17, 1959 , that I last saw the deceased alive on 6-15-1959 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George R. Huffman		ADDRESS (Street, city or town, state) 1912 R. Street, N. W.	
PHYSICIAN'S NAME (Type) George R. Huffman		DATE SIGNED 6/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/19/59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	22d. LOCATION (City, town, or county) (State) Prince George Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUN 19 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knaus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6917 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Deborah Middle Ann Last BROOKS		4. DATE OF DEATH Month June Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 April 1959
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 13	
11. IF UNDER 24 HRS. Hours 13 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas M. Brooks		14. MOTHER'S MAIDEN NAME Florence Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT (Mother) Mrs. Florence Brooks Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 757.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extrophy of bladder (congenital) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 May , 19 59 , to 10 June , 19 59 , that I last saw the deceased alive on 10 June , 19 59 , and that death occurred at 3:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED ACTUAL SIGNATURE H. L. Walton M.D. U. S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) H. L. WALTON LT MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 JUNE 59	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter S. Hall Cunningham's		24a. REC'D BY REGISTRAR JUN 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

NAME

DECEASED (Name)

DATE

J. E. HENRY, HOSPITAL, BALTIMORE, MD.

220 E. HENRY AVENUE

RESIDENCE

PROVIDENCE

22 April 1917

EDWARD A. HENRY

22 HENRY DRIVE

(Mother) Mrs. PROSPER HENRY, MRS. DE

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF DECEASED		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHURCH		18. SIGNATURE OF BURIAL		19. SIGNATURE OF CREMATION		20. SIGNATURE OF OTHER	
21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER	
26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER	
36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER	
56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER	
66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06884

6919 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>Louise</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>6.11.</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.18.81</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Charles A. Gartrell</u>			
14. MOTHER'S MAIDEN NAME <u>Virginia Grooms</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pyelonephritis with numerous abscesses - acute necrotizing cystitis</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Bronchopneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>3/1/58</u> , 19 <u>58</u> , to <u>6/1/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/1/59</u> , 19 <u>59</u> , and that death occurred at <u>8:45 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird, M. D.</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u>		DATE SIGNED <u>6/1/59</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>				M.D. <u>Sandy Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Sunshine Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6920

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Utah b. COUNTY Salt Lake City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 68 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle William Last BROWN				4. DATE OF DEATH Month June Day 23 Year 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-23	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Foster BROWN				14. MOTHER'S MAIDEN NAME Estella REESE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7/41 to DOD 561-26-5416		INFORMANT Address (W) Mrs. Louella C. Brown, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA & SEPTICEMIA (BILATERAL) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LEUKOPENIA & APLASTIC ANEMIA DUE TO (c) TOTAL BODY IRRADIATION OF 700 R GIVEN 4 WEEKS						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 4 WEEKS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) CARCINOMA OF TESTES. OF 7 YEAR'S DURATION							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27 , 19 59 , to June 23 , 19 59 , that I last saw the deceased alive on June 22 , 19 59 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 6/23/59							
ACTUAL SIGNATURE F. S. Caldwell M.D. U. S. Naval Hospital							
PHYSICIAN'S NAME (Type) F. S. Caldwell, LT, MC, USN Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 6-28-59		22c. NAME OF CEMETERY OR CREMATORY Army Cemetery		22d. LOCATION (City, town, or county) (State) Fort Douglas Utah	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest A. Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave. NW, Washington, DC				24a. REC'D BY REGISTRAR JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

6980 CERTIFICATE OF DEATH

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Date of Death

69 years

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6875 CERTIFICATE OF DEATH

06886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>47X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>				d. STREET ADDRESS <i>1300 Vermont Ave N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Myrtie</i> Middle <i>Lee</i> Last <i>Bunch</i>				4. DATE OF DEATH Month <i>6</i> Day <i>21</i> Year <i>1959</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-15-84</i>	
9. AGE (In years last birthday) <i>74</i> YES <input checked="" type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Chandler</i>				14. MOTHER'S MAIDEN NAME <i>Gabriel Bunch</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Husband + old W.S.H. Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> <i>420.1</i> DUE TO <i>Chronic Myocarditis Angina</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Severe Aortic Aneurysm</i> DUE TO <i>Severe Aortic Aneurysm</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>RT lobar pneumonia - left lobar bronchopneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>1/7/59</i>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <i>6</i> Day <i>21</i> Year <i>1959</i> Hour <i>a.m.</i> <i>19</i> <i>p.m.</i>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1/21/59</i> , 19 <i>59</i> , to <i>6/21/59</i> , that I last saw the deceased alive on <i>6/21/59</i> , 19 <i>59</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard T. Moore</i> M.D.				ADDRESS (Street, city or town, state) <i>7030 Carroll Ave</i> DATE SIGNED <i>6/21/59</i>			
PHYSICIAN'S NAME (Type) <i>Takoma Park, Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/23-1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cem</i>		22d. LOCATION (City, town, or county) (State) <i>HYATTSVILLE, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edith Henry Funeral Home</i> ADDRESS <i>4217 9th St DC</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6921 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING d. STREET ADDRESS X XXXXX e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON WALTER BURRIS				4. DATE OF DEATH Month Day Year JUNE 24 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/27/12	
9. AGE (In years last birthday) yrs. 47		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GAS STATION ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME FRANK WALTER BURRIS				14. MOTHER'S MAIDEN NAME NORAELEN BURRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-0309091		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from esophageal varices 10 da 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) Chronic Alkalosis							INTERVAL BETWEEN ONSET AND DEATH unla. unla.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14, 1959 , to June 24, 1959 , that I last saw the deceased alive on June 24, 1959 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur F. Woodward M.D.				ADDRESS (Street, city or town, state) Rockville - Md.		DATE SIGNED 6/24/59	
PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD, M. D.				ROCKVILLE, MARYLAND		6/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27 -59		22c. NAME OF CEMETERY OR CREMATORY Brookeville Meth.		22d. LOCATION (City, town, or county) (State) Brookeville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH BALTIMORE 12

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

SEX

AGE

EDUCATION

DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6876 CERTIFICATE OF DEATH

06888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>83x-3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan. + hospital</u>				d. STREET ADDRESS <u>1415 N. Hudson Street</u>					
3. NAME OF DECEASED (Type or print) <u>Grace Carrolle Burton</u>				4. DATE OF DEATH <u>June 20, 1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-87</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas J. Cousins</u>				14. MOTHER'S MAIDEN NAME <u>Bosa Traylor</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Chart</u>		17. INFORMANT <u>Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Cerebral Infarction + Hypertension</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that I attended the deceased from <u>June 19, 1959</u> , to <u>June 20, 1959</u> , that I last saw the deceased alive on <u>June 19, 1959</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., T.P. Md.</u>					
PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD.</u>				DATE SIGNED <u>6/20/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 24, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLLYWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RICHMOND, VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Frank</u>				24a. REC'D BY REGISTRAR <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06889

Weight - 3 lbs 11 oz

6922

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buchard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bussink</u>		4. DATE OF DEATH Month Day Year <u>JUNE 10 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10 1959</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Francis Bussink</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA Dynosia AUTH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FATHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital atelectasis</u> (c) <u>Immaturity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>59</u> , to <u>June 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>JAMES S STANTON MD</u>		DATE SIGNED <u>6/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Collins</u>		24a. REC'D BY REGISTRAR <u>3821-14 ST. NW. WASH. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>JUN 15 '59</u>	

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1928

CERTIFICATE OF DEATH

Age - 30

Walter
Frederick

Suburban Hospital

Walter
Frederick

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June 10 1928

Male

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June 10 1928

Robert Francis

Patric

June 10 1928

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6923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, /if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 17, 1891</u> 9. AGE (In years last birthday) <u>67</u> yrs. 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u> 11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Caggiano</u> Last <u></u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Supv. U.A.</u>			
11. BIRTHPLACE (State or foreign country) <u>Boston - MASS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GAETANO CAGGIANO</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT <u>Wife</u> <u>Madeleine Caggiano</u>				Address <u>Same as Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <u>Subacute bacterial endocarditis</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>Cerebral aneurysm</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u></u> DUE TO <u></u>							
(c) <u></u> DUE TO <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/1/59</u> , 19 <u>59</u> , to <u>6/15/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10:00 PM</u> , 19 <u>59</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr Joseph Kenrick</u>				ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u>				DATE SIGNED <u>6/16/59</u>			
22a. BURIAL, CREMATION, 22b. DATE THEREOF <u>Burial - Transit 6-20-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery.</u>			
22d. LOCATION (City, town, or county) (State) <u>Malden, Mass.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>			
24a. REC'D BY REGISTRAR <u>JUN 19 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. The attending physician, after the death certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
ISM 9/58

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6924 CERTIFICATE OF DEATH

Reg. Dist. No.

06891

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Wash., D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Sanitarium</i>		d. STREET ADDRESS <i>3610 Massachusetts Ave., N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>J. C. Kennedy Campbell</i>		4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-27-1870</i>
9. AGE (In years lost birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash., D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Leonidas C. Campbell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kennedy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Kennedy C. Hatties</i>	
17. INFORMANT Address <i>3610 Mass. Ave., N.W.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, bilateral</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Debility from pyelonephritis</i> (c) <i>gent advanced arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>14 days</i> <i>4 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Sept</i> , 1956, to <i>June</i> , 1959, that I last saw the deceased alive on <i>June 14</i> , 1959, and that death occurred at <i>7:40 PM</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>James C. Gannon</i> M.D. <i>3141 34th St NW</i>		DATE SIGNED <i>6-15-59</i>	
PHYSICIAN'S NAME (Type) <i>JAMES A. GANNON, JR.</i>		<i>Washington D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>June 18/59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Congressional</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest A. Adams</i>		24a. REC'D BY REGISTRAR <i>4748-Wis ave</i>	
24b. REGISTRAR'S SIGNATURE <i>Washington D.C.</i>		DATE <i>JUN 18 '59</i>	

CERTIFICATE OF DEATH

See Dist. No.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES A. JONES		45		M		W		1878		BALTIMORE, MD.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		NAME OF MINISTER		NAME OF FUNERAL HOME	
April 15, 1921		Baltimore, Md.		April 17, 1921		St. Mary's Church		Rev. J. J. Jones		J. J. Jones & Co.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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1935 CERTIFICATE OF DEATH

Decedent's Name: Cheney Chase
 Date of Birth: January 3, 1878
 Sex: Female
 Race: White
 Marital Status: Married
 Usual Residence: New York

Place of Death: 2112 Kensington Drive

Cause of Death: Al. Carb.

Date of Death: January 3, 1935

Place of Burial: Housewife

Signature of Physician: Cheney

Signature of Undertaker: William J. Carey

Signature of Registrar: None

Signature of Coroner: None

Signature of Medical Examiner: None

Signature of Health Officer: None

Signature of Police Officer: None

Signature of Fire Department: None

Signature of Sanitation Department: None

Signature of Board of Health: None

Signature of Board of Education: None

Signature of Board of Social Services: None

Signature of Board of Charities: None

Signature of Board of Pensions: None

105303

STATE OF NEW YORK
DEPARTMENT OF HEALTH

10-11-1914
J. J. ...
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6927 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 97 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda				d. STREET ADDRESS 9525 Milstead Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Clifton CARSON				4. DATE OF DEATH Month Day Year June 18 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-04	9. AGE (In years lost birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchmaker		10b. KIND OF BUSINESS OR INDUSTRY Merchandising		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. CARSON				14. MOTHER'S MAIDEN NAME Annie Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 3/42 to 12/43		INFORMANT Address (W) Mrs. Ruby B. Carson, same as item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Carcinomatous DUE TO Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Due to (c) lying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 8 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to June 18 , 19 59 , that I last saw the deceased alive on June 18 , 19 59 , and that death occurred at 4:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 6-19-59							
ACTUAL SIGNATURE Douglas R. Koth M.D.				U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) Douglas R. KOTH, LT MC, USN				Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS R.A. Humphrey Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
				24b. REGISTRAR'S SIGNATURE Clarence S. Thomas			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

[illegible]

10-10-9

Estadística de la agricultura

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• <http://www.ck12.org>

DOI: 10.1002/for

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References

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

CERTIFICATE OF DEATH

116895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 4x 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE d. STREET ADDRESS WASHINGTON GROVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ERNEST CATOR				4. DATE OF DEATH Month Day Year JUNE 22 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/90	
9. AGE (In years last birthday) yrs. 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER		10b. KIND OF BUSINESS OR INDUSTRY A. GUDE & SONS		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDWARD CATOR		14. MOTHER'S MAIDEN NAME MARTHA HENDERSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of Prostate Gland DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prostate Gland DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 1952 to June 22, 1959 , that I last saw the deceased alive on June 21, 1959 , and that death occurred at 2:40 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GAITHERSBURG, MARYLAND DATE SIGNED 6-22-59							
ACTUAL SIGNATURE Jack Schumacher M.D.				PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Potomac Cemetery	
22d. LOCATION (City, town, or county) Potomac, Maryland				22e. (State) MARYLAND		23. FUNERAL DIRECTOR'S SIGNATURE Ed. Galt	
ADDRESS 316 E Diamond Gaithersburg, Md				24a. REC'D BY REGISTRAR JUN 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6929

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>27 hrs</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>	
d. STREET ADDRESS <u>Glen Mill. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Cavanaugh</u> Last <u>Cavanaugh</u>		4. DATE OF DEATH Month <u>6</u> - Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin T. Cavanaugh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ganey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mary E. Cavanaugh</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>976X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal hemorrhage</u> DUE TO <u>Shot gun wound in abdomen</u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:50 p.m. 6-8 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State) <u></u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>June 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanea</u>	

MEDICAL CERTIFICATION

2

10-15-52

Handwritten: Mary G. Connelley
Mortimer J. Connelley
10-15-52

Handwritten: Mortimer J. Connelley
10-15-52
Mortimer J. Connelley

TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the funeral director. After the certificate has been filed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6930

CERTIFICATE OF DEATH

06897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>49 days</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ontario, Canada</u> b. COUNTY <u>70 x - 3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toronto</u> d. STREET ADDRESS <u>26 Madison Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion Mary Chernick</u>			4. DATE OF DEATH Month Day Year <u>June 24, 19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1910</u>		9. AGE (In years lost, birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>
13. FATHER'S NAME <u>Ozarko Stanley</u>			14. MOTHER'S MAIDEN NAME <u>Christine Galet</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia and Shock</u> <u>1957</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary Tract Infection</u> DUE TO (c) <u>Adenocortical Carcinoma with Cushing's Syndrome</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 Hours</u> <u>72 Hours</u> <u>2 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 6, 1959</u> to <u>June 24, 1959</u> , that I last saw the deceased alive on <u>June 24, 1959</u> and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>6-25-59</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>					
ACTUAL SIGNATURE <u>Richard H. Moy</u> M.D.		PHYSICIAN'S NAME (Type) <u>Richard H. Moy, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit 6/26/59</u>		22b. DATE THEREOF <u>6/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Toronto, Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24d. LOCATION (City, town, or county) (State) <u>Ontario, Canada</u>			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral home. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										46898				
Kensington, Md.										CERTIFICATE OF DEATH				
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <u>Kensington, Montgomery Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Johns Hopkins</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elizabeth Chase</u>					d. STREET ADDRESS <u>14 West Annapolis St.</u>									
3. NAME OF DECEASED (Type or print) <u>Anne</u> First <u>Eliza</u> Middle <u>Chapin</u>					4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1959</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1915</u>		9. AGE (In years last birthday) <u>43</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
13. FATHER'S NAME <u>WARREN CHATE</u>					14. MOTHER'S MAIDEN NAME <u>KATHERINE RAGAN</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>None</u>					INFORMANT Address <u>Allison Chapin - Niece - same as 2d</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cardiac failure, congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, arteriosclerotic disease</u> (c) <u>with cerebral accident + paralysis, legs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>16 mos.</u> <u>15 yrs.</u> <u>10 mos.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that I attended the deceased from <u>Sept. 1958</u> to <u>June 28, 1959</u> that I last saw the deceased alive on <u>June 27, 1958</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Philip H. Varner</u>					M.D. <u>10,620 Ga. Ave., Silver Spring, Md.</u>					DATE SIGNED <u>6-28-59</u>				
PHYSICIAN'S NAME (Type) <u>Philip H Varner</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>7/1/59</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>				
22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>					23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>														

Kenneth, 1914

Kenneth, Maryland Co.

Kenneth, 1914

Class



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6932

CERTIFICATE OF DEATH

06899

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Johnson's Nursing Home		d. STREET ADDRESS 1244 E St., N.E.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILBER Middle AUSTIN Last COPELAND		4. DATE OF DEATH Month JUNE Day 26 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/76
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Printing Office	
11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME SARAH MITCHELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mrs. Robert M. Johnson, R.#1, Box 224		Address Boyd's, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1959 , to June 26, 1959 , that I last saw the deceased alive on June 25, 1959 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. F. Thibadeau		M.D. 10111 Colesville Rd.	
PHYSICIAN'S NAME (Type) A. F. THIBADEAU		ADDRESS (Street, city or town, state) Silver Spring, Md.	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 6/29/59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

6933

CERTIFICATE OF DEATH

06900

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanatorium</u>				d. STREET ADDRESS <u>7507 Arlington Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>H.</u> Last <u>Craig</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1874</u>		9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>	
13. FATHER'S NAME <u>John F. Hill</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Guthrie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Conis P. Allwine 1411 Rockville Pike</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Polar Pneumonia</u> 331X DUE TO <u>Cerebral Accident of 2 mos duration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/16</u> , 19 <u>59</u> , to <u>6/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>59</u> , and that death occurred at <u>6:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wheeler O. Huff</u>				ADDRESS (Street, city or town, state) <u>4529 Maple Ave, Bethesda, Md.</u>			
DATE SIGNED <u>July 1, 1959</u>							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill C.E.</u>		22d. LOCATION (City, town, or county) (State) <u>Shippensburg Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Jones</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06901

6934

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> <u>3509 Stark Street</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Danilowicz</u> Last <u></u>		4. DATE OF DEATH Month <u>June</u> Day <u>5th</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3RD 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) DANILOWICZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>199-14-4172</u>	
17. INFORMANT <u>JOSEPH DANILOWICZ</u>		Address <u>3509-STARKE ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>57</u> , to <u>June 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>59</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>John E. Everett</u> M.D. <u>9400 CONN. AV. KENSINGTON</u>			
PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		<u>9400- CONN. AVE. KENSINGTON, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Wheaton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Houlton</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>	
ADDRESS <u>3831 Ga. Ave. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Christ S. Hunt</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1914	
NAME OF DECEASED JAMES M. HARRIS		SEX Male	
AGE 45		OCCUPATION Laborer	
PLACE OF BIRTH Baltimore, Md.		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1914		TIME OF DEATH 10:30	
PLACE OF DEATH Baltimore, Md.		NAME OF PHYSICIAN Dr. J. M. Harris	
NAME OF FUNERAL HOME Harris Funeral Home		NAME OF BURIAL PLACE St. James Cemetery	
NAME OF NEXT OF KIN Mrs. J. M. Harris		NAME OF WITNESS Dr. J. M. Harris	
NAME OF REGISTRAR J. M. Harris		NAME OF CLERK J. M. Harris	

6935

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS Cherry Hill Traylor Pk. #10 1st St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Evelyn Opal DAVIS			4. DATE OF DEATH Month Day Year June 3 19 59		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 May 1932	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Store Chain		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Opal Scott			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. (Husband) Hugh L. DAVIS Same as #2			17. INFORMANT Address (Husband) Hugh L. DAVIS Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheal Compression 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Mediastinal Infiltration (c) Acute Blastic Leukemia					INTERVAL BETWEEN ONSET AND DEATH 1 week 4 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Savannah	(County) Georgia	(State) Georgia
21. I certify that I attended the deceased from 1 June , 19 59 , to 3 June , 19 59 that I last saw the deceased alive on 3 June , 19 59 , and that death occurred at 11:40 PM , from the causes and on the date stated above. F. H. O'Connell F. H. O'CONNELL LT MC USN U.S. Naval Hospital, Bethesda Md. 6-4-59 F. H. O'CONNELL LT MC USN U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-59		22c. NAME OF CEMETERY OR CREMATORY Bonaventure	
22d. LOCATION (City, town, or county) Savannah		(State) Georgia			
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Francis Sons		ADDRESS 4739 Baltimore Ave. Hyattsville Md.		24a. REC'D BY REGISTRAR 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna					

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After certificate has been signed by the attending physician and completed by filled in by the General Director, TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by filled in by the General Director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06903

Items 18&21 Film 245 7-22-59

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District Columbia</u> by COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>1400 Longfellow St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Mary</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miss</u>	
11. BIRTHPLACE (State or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>NATHAN DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Buck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Washington Sanitarium</u>	
17. INFORMANT <u>Takeima Park R. M.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hematoma.</u> <u>903.0</u> DUE TO <u>right, frontal and</u> <u>Subarachnoid hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>both post-traumatic</u> (c) <u>aneurysm of right cerebellar</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and struck forehead and occiput - in Kitchen of home</u>	
20c. TIME OF INJURY Hour a. m. p. m. <u>May 24 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington D.C.</u>	
21. I certify that I attended the deceased from <u>29 May, 1959</u> to <u>5 June, 1959</u> , that I last saw the deceased alive on <u>5 June, 1959</u> , and that death occurred at <u>9:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington D.C.</u> DATE SIGNED <u>5 June 59</u>			
ACTUAL SIGNATURE <u>Robert A. Mendelsohn</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert A. Mendelsohn M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat</u>		22d. LOCATION (City, town, or county) (State) <u>St. Marys D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEE FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
ADDRESS <u>300. 4th ST NE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MATHAN DAVID



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6877 CERTIFICATE OF DEATH

06904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tekoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8714 First Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>John</u> Last <u>Dickinson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-9-98</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>00</u> Hours <u>00</u> Min.		IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>American Seale Co.</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Fred H. Dickinson</u>				14. MOTHER'S MAIDEN NAME <u>BABETTE WIRTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>57901-7051</u>		17. INFORMANT <u>Hospital Admitting Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage - upper G.I.</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophageal Varices</u> (c) <u>Cirrhosis of the Liver</u> INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Unknown</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arricular Fibrillation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 23, 1959</u> to <u>June 23, 1959</u> , that I last saw the deceased alive on <u>June 23, 1959</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Hare</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, Takoma Park, Md.</u> DATE SIGNED <u>6/23/59</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u> DATE <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

6937

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 2125 34th Street, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Francis DIETRICH				4. DATE OF DEATH Month Day Year June 29 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-93	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry DIETRICH				14. MOTHER'S MAIDEN NAME Anna SCHWAB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI - WWII		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X Polysuany Edema DUE TO (b) Sec. to ASD and Pneumonia DUE TO (c) Multiple Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 yrs 3 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29 , 19 59 , to June 29 , 19 59 that I last saw the deceased alive on June 29 , 19 59 , and that death occurred at 10:50 PM , from the causes and on the date stated above. F. H. O'Connell ACTUAL SIGNATURE ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 6-30-59 M.D.							
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS Lee Funeral Home, 4th & Mass. Ave. NE, Wash., DC				24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH

REPORT

1900

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

NAME OF PHYSICIAN

HOSPITAL

DATE OF DEATH

NAME OF PHYSICIAN

HOSPITAL

DATE OF DEATH

NAME OF PHYSICIAN

HOSPITAL

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NAME OF PHYSICIAN

HOSPITAL

DATE OF DEATH

6938

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE d. STREET ADDRESS 243 NORTH ADAMS STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BRUCE TERRY DIFFENDERFER		4. DATE OF DEATH Month Day Year JUNE 30 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/57
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 9 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME TERRY BRUCE DIFFENDERFER		14. MOTHER'S MAIDEN NAME WANDA L. WOODWARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I attended the deceased from 6/29 19 59 , to 6/30/59 , 19 59 , that I last saw the deceased alive on 6/30/59 , 19 59 , and that death occurred at 12:50 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/30/59			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE L. I. Leal M.D.		PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/59	
22c. NAME OF CEMETERY OR CREMATORY Lee Memorial Cem.		22d. LOCATION (City, town, or county) (State) Woodway, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1945 (Rev. 5)

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX MALE</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH JANUARY 5, 1910</p>	
<p>5. PLACE OF BIRTH MOBILE, ALABAMA</p>		<p>6. OCCUPATION AIR FORCE</p>	
<p>7. MARITAL STATUS SINGLE</p>		<p>8. RACE WHITE</p>	
<p>9. DATE OF DEATH APRIL 4, 1968</p>		<p>10. TIME OF DEATH 6:01 PM</p>	
<p>11. PLACE OF DEATH MEMPHIS, TENNESSEE</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. MANNER OF DEATH ACCIDENT</p>		<p>14. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>15. SIGNATURE OF REGISTRAR [Signature]</p>		<p>16. SIGNATURE OF WITNESS [Signature]</p>	

6939

CERTIFICATE OF DEATH

06907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California 18X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS Town Creek Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilma Marie Dinterman				4. DATE OF DEATH Month Day Year June 12 19 59			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 February 1918		9. AGE (In years last birthday) yrs. 41	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herman Busacker				14. MOTHER'S MAIDEN NAME Wanda (Dinterman) Jennie Wafer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		INFORMANT Address (husband) Roger Alfred DINTERMAN Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (duration - one week) 053.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 June 19 59 , to 12 June 19 59 , that I last saw the deceased alive on 12 June 19 59 , and that death occurred at 12:35 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. McFarland</i> M.D. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED PHYSICIAN'S NAME (Type) W. McFarland CDR MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 17 June 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>David S. Brandt</i> Everly Funeral Home, Fairfax, Virginia				24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

Montgomery County Medical Examiner notified.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2939

CERTIFICATE OF DEATH

Married

Deceased

John Cross

Birth

1918

Married

Married (Married)

(Married) (Married)

(Married) (Married)

22

10

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

U.S. Naval Hospital, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06908

6940

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHLAND 13X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AMELIA OLIVIA DISNEY				4. DATE OF DEATH Month Day Year JUNE 3 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/71	
9. AGE (In years last birthday) yrs. 88		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME BOWIE JOHNSON			
14. MOTHER'S MAIDEN NAME LOUANN THOMPSON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. -				17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF RECTUM DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA DUE TO NEPHROSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 5 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 46 , to JUNE 3 , 19 59 , that I last saw the deceased alive on JUNE 3 , 19 59 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 6/3/59 ACTUAL SIGNATURE C. S. Whitaker, M.D. M.D. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D. SANDY SPRING, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-59		22c. NAME OF CEMETERY OR CREMATORY Mt Zion		22d. LOCATION (City, town, or county) (State) Highland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE JUN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN 1b 35 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 100 University Avenue			d. STREET ADDRESS 100 University Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Coralie Livingston Bell Douglas			4. DATE OF DEATH Month June Day 21 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1875		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Henry Bell			14. MOTHER'S MAIDEN NAME Ellen Ragan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Eloise D. Graham - Item #2-daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inhalation of smoke + fumes DUE TO (c) Leaving home					INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2nd + 3rd degree burn of extremities, head + neck					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House fire			
20c. TIME OF INJURY Month, Day, Year 2-21-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Glen Echo Montg. Md		20g. (County) Montgomery		20h. (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. FRANK J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Tran.-Bur.		22b. DATE THEREOF 6/24/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown, Maryland		22e. (State) Md		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Huns					

6878

CERTIFICATE OF DEATH

06910

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>68 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>6833 EASTERN Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ZILPHA</u> Middle <u>MINNIE</u> Last <u>DOUGLAS</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>FE</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1858</u>	
9. AGE (In years last birthday) <u>100</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>? CHILDS.</u>				14. MOTHER'S MAIDEN NAME <u>(unknown by informant)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Willard R. Douglas - (son)</u> Address <u>(abroad)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>June</u>	
20f. (City or town) <u>June</u>				(County) <u> </u>		(State) <u> </u>	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>April 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>59</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>6216 N.H. Ave NE</u>				DATE SIGNED <u>6/12/59</u>			
ACTUAL SIGNATURE <u>William F. Simpson, Jr.</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM F Simpson Jr</u>				<u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08010

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]	
4. DATE OF DEATH [Date]		5. TIME OF DEATH [Time]		6. PLACE OF DEATH [Place]	
7. CAUSE OF DEATH [Cause]		8. MANNER OF DEATH [Manner]		9. SIGNATURE OF DECEASED [Signature]	
10. SIGNATURE OF WITNESS [Signature]		11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF CLERK [Signature]	
13. SIGNATURE OF JUDGE [Signature]		14. SIGNATURE OF SHERIFF [Signature]		15. SIGNATURE OF CORONER [Signature]	
16. SIGNATURE OF DISTRICT ATTORNEY [Signature]		17. SIGNATURE OF COUNTY CLERK [Signature]		18. SIGNATURE OF CITY CLERK [Signature]	
19. SIGNATURE OF MAYOR [Signature]		20. SIGNATURE OF COMMISSIONER [Signature]		21. SIGNATURE OF DEPUTY COMMISSIONER [Signature]	
22. SIGNATURE OF ASSISTANT COMMISSIONER [Signature]		23. SIGNATURE OF CHIEF CLERK [Signature]		24. SIGNATURE OF CLERK [Signature]	
25. SIGNATURE OF CLERK [Signature]		26. SIGNATURE OF CLERK [Signature]		27. SIGNATURE OF CLERK [Signature]	
28. SIGNATURE OF CLERK [Signature]		29. SIGNATURE OF CLERK [Signature]		30. SIGNATURE OF CLERK [Signature]	
31. SIGNATURE OF CLERK [Signature]		32. SIGNATURE OF CLERK [Signature]		33. SIGNATURE OF CLERK [Signature]	
34. SIGNATURE OF CLERK [Signature]		35. SIGNATURE OF CLERK [Signature]		36. SIGNATURE OF CLERK [Signature]	
37. SIGNATURE OF CLERK [Signature]		38. SIGNATURE OF CLERK [Signature]		39. SIGNATURE OF CLERK [Signature]	
40. SIGNATURE OF CLERK [Signature]		41. SIGNATURE OF CLERK [Signature]		42. SIGNATURE OF CLERK [Signature]	
43. SIGNATURE OF CLERK [Signature]		44. SIGNATURE OF CLERK [Signature]		45. SIGNATURE OF CLERK [Signature]	
46. SIGNATURE OF CLERK [Signature]		47. SIGNATURE OF CLERK [Signature]		48. SIGNATURE OF CLERK [Signature]	
49. SIGNATURE OF CLERK [Signature]		50. SIGNATURE OF CLERK [Signature]		51. SIGNATURE OF CLERK [Signature]	
52. SIGNATURE OF CLERK [Signature]		53. SIGNATURE OF CLERK [Signature]		54. SIGNATURE OF CLERK [Signature]	
55. SIGNATURE OF CLERK [Signature]		56. SIGNATURE OF CLERK [Signature]		57. SIGNATURE OF CLERK [Signature]	
58. SIGNATURE OF CLERK [Signature]		59. SIGNATURE OF CLERK [Signature]		60. SIGNATURE OF CLERK [Signature]	
61. SIGNATURE OF CLERK [Signature]		62. SIGNATURE OF CLERK [Signature]		63. SIGNATURE OF CLERK [Signature]	
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3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. SIGNATURE OF DECEASED
10. SIGNATURE OF WITNESS
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF CLERK
13. SIGNATURE OF JUDGE
14. SIGNATURE OF SHERIFF
15. SIGNATURE OF CORONER
16. SIGNATURE OF DISTRICT ATTORNEY
17. SIGNATURE OF COUNTY CLERK
18. SIGNATURE OF CITY CLERK
19. SIGNATURE OF MAYOR
20. SIGNATURE OF COMMISSIONER
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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6942

CERTIFICATE OF DEATH

06912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BROOKEVILLE d. STREET ADDRESS BROOKEVILLE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN AGNES DOWNS		4. DATE OF DEATH Month JUNE Day 30 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/90
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM MATULEWICH		14. MOTHER'S MAIDEN NAME JENNY NAGNORWSKI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Secondary Anemia DUE TO (c) Metastatic Carcinoma of Uterus			INTERVAL BETWEEN ONSET AND DEATH 6 days 2 months 1 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1958 , to June 30, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 2:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brookeville Md. DATE SIGNED 6-30-59			
ACTUAL SIGNATURE Richard A. Yates M.D.		PHYSICIAN'S NAME (Type) RICHARD A. YATES, M. D. OLNEY, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 3, 59	22c. NAME OF CEMETERY OR CREMATORY Brookeville	22d. LOCATION (City, town, or county) (State) Brookeville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gray W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6943

CERTIFICATE OF DEATH

06911

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gaithersburg	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret R. Duvall		4. DATE OF DEATH Month 6 - Day 29 - Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-96
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Raab		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT C. Vernon Duvall, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 260X DUE TO cardiovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) diabetes mellitus (c)		INTERVAL BETWEEN ONSET AND DEATH 15 days 3 days 35 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15, 1946 , to 6/29, 1959 , that I last saw the deceased alive on 6/28, 1959 , and that death occurred on 6/29, 1959 , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kern		ADDRESS (Street, city or town, State) Damascus, Md.	
PHYSICIAN'S NAME (Type) Oliver L. McNamee		DATE SIGNED 7/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/59	
22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. McNamee		24a. REC'D BY REGISTRAR DATE JUL 2 '59	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital, or attending physician, or funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1911

Form No. 1

DEATH CERTIFICATE

NAME OF DECEASED

RESIDENCE

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF FUNERAL HOME

NAME OF BURIAL PLACE

NAME OF INTERMENT

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISPOSITION

NAME OF REMAINS

NAME OF REMAINS

NAME OF REMAINS

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NAME OF REMAINS

6944

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beth. Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clifton E. Eldridge		4. DATE OF DEATH Month June Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1887
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mac. Naval Gun Factory	
11. BIRTHPLACE (State or foreign country) India na		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Simeon Eldridge		14. MOTHER'S MAIDEN NAME Augusta Crosier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Adelaide L. Eldridge		Address 9010 Bradford Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dissecting abdominal aortic aneurysm			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 48 to 20 June, 1959 , that I last saw the deceased alive on 20 June , 19 59 , and that death occurred at 11:05 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.		ADDRESS (Street, city or town, state) 9006 Colesville Rd DATE SIGNED 6/20/59	
PHYSICIAN'S NAME (Type) William D. Aud		Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/59	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Res. Funeral Home		ADDRESS 4812 Ga. Ave	
24a. REC'D BY REGISTRAR 25 '59		24b. REGISTRAR'S SIGNATURE Crispin E. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CONTINUED

Charles P. Thompson
Colton

I was born at Colton, Md.

27 June 1901
1802 AM

27 June 1901
1802 AM
Colton, Md.

27 June 1901
1802 AM
Colton, Md.

6896

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN lb 26		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 713 Mapleton Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE A. ELMORE		4. DATE OF DEATH Month Day Year June 13, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days 1 12	11. IF UNDER 24 HRS. Hours Min. 1 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George M. Elmore		14. MOTHER'S MAIDEN NAME Mary Houser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-30-3571	
17. INFORMANT Lillian E. Elmore-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Cachexia & anemia DUE TO (b) metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) carcinoma of liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema INTERVAL BETWEEN ONSET AND DEATH 1 wk 6 mos. 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/1 , 19 54 , to 6/13 , 19 59 , that I last saw the deceased alive on 6/13 , 19 59 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Maryland DATE SIGNED 6/13/59 ACTUAL SIGNATURE Stephen N. Jones M.D. PHYSICIAN'S NAME (Type) Stephen N. Jones-Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/15/59	22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	22d. LOCATION (City, town, or county) (State) Leesburg, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Montgomery

Warrick

Montgomery

Rockville

113 Madison Drive

113 Madison Drive

June 13

A. RAMON

GEORGE

May 1, 1885

White

White

12

Virginia

Washington

Birth of

Harry Houser

George M. Ramon

2-2-30-3571 Lillian E. Ramon-Iron 3

No

James H. Jones-Rockville, Maryland

Montgomery, Virginia

Union Cemetery

White

Local

Robert A. Thompson-Baltimore, Maryland

06915

Reg. Dist. No.

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FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, it must be filed in the appropriate space provided. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET G FIRPATRICK</u>		4. DATE OF DEATH Month Day Year <u>6 8 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/88</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTERED NURSE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
12. BIRTHPLACE (State or foreign country) <u>Rathfriland, Ireland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Edward Liblin</u>		15. MOTHER'S MAIDEN NAME <u>Honora Liblin</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. SOCIAL SECURITY NO. <u>—</u>	
18. INFORMANT <u>Hospital Records</u>		Address <u>SUBURBAN H. Bethesda, Md</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction - abdominal</u> <u>454X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		21b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21d. (City or town) (County) (State)	
22. I certify that I attended the deceased from <u>6/8</u> , 19 <u>59</u> , to <u>6/8</u> , 19 <u>59</u> that I last saw the deceased alive on <u>6/8</u> , 19 <u>59</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>2800 Reservoir Rd. N.W. Washington, D.C.</u>	
ACTUAL SIGNATURE <u>Chas A. Hufnagle</u>		DATE SIGNED <u>6/8/59</u>	
PHYSICIAN'S NAME (Type) <u>THAS. A. HUFNAGLE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>—</u>		22d. LOCATION (City, town, or county) (State) <u>BUFFALO, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson Co.</u>		ADDRESS <u>1300 N. St. NW D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUN 10 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

11/1/11
11/1/11
11/1/11

11/1/11

11/1/11

11/1/11

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

6897 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Gaithersburg</i>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <i>R70 # 2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>md 18-115</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elmer Sidney Fitzwater</i>		4. DATE OF DEATH <i>June 4 19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-21-85</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter Building Con.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>West Virginia</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
13. FATHER'S NAME <i>Cyprianus Fitzwater</i>		14. MOTHER'S MAIDEN NAME <i>Clarenda Delawder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Cora Fitzwater</i>		Address <i>Same As 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO (b) <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Hemorrhage into Atherosclerotic plaque</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Hours</i> <i>Hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Mucoid obstruction of trachea and aspiration gastric contents</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschant</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 6</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Valley View</i>		22d. LOCATION (City, town, or county) (State) <i>Nokesville Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W. Barber</i>		24a. REC'D BY REGISTRAR <i>DATE JUN 8 '59</i>	
ADDRESS <i>Laytonsville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

2

2



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John Fitzgerald
AGE: 2

RESIDENCE: 1000 Broadway, New York City
OCCUPATION: Clerk

DATE OF DEATH: 10/10/1918
PLACE OF DEATH: 1000 Broadway, New York City
CAUSE OF DEATH: Influenza
MANNER OF DEATH: Natural

SEX: Male
RACE: White
RELIGION: Catholic
EDUCATION: High School
MARRIED: Yes
SINGLE: No
WIDOWED: No
DIVORCED: No

SIGNATURE OF EXAMINER: [Signature]
DATE: 10/10/1918
PLACE: Baltimore, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.



6946

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Filing 244 7-8-59 et

06917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp</u>		d. STREET ADDRESS <u>Watkins Rd. R-1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William T.</u> Middle <u>Flynn</u> Last <u>Jr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co., Maryland</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wm. T. Flynn Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Ada Mullnix</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-28-2136</u>		17. INFORMANT <u>Police Record.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>835X</u> DUE TO <u>crushed neck and chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Driver of farm tractor which upset</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>1:00</u> <u>XX</u> <u>6/29/59</u> Hour <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) (County) (State) <u>Woodfield Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/29/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Howard Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Long Corner, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molemanth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6947

CERTIFICATE OF DEATH

06918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Eleanor</u> Last <u>Ford</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker-Book Bindery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Worker-Bookbindery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel C. Ford</u>		14. MOTHER'S MAIDEN NAME <u>Arne C. Redner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-3405</u>	
17. INFORMANT <u>Asbury Methodist Home for the Aged</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5-26-59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-4</u> , 19 <u>58</u> , to <u>6-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-8</u> , 19 <u>59</u> , and that death occurred at <u>1:30P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		ADDRESS (Street, city or town, state) <u>10125 CEDAR LANE</u> <u>WENNINGTON, MD.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Sarah Elizabeth Glover</u>		DATE SIGNED <u>6-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. T. Tucker & Sons - Balto.</u>		ADDRESS <u>17</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

06919
Reg. Dist. No.

6948

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6505 Callander Drive		d. STREET ADDRESS 14 Bryant Street N. W.	
3. NAME OF DECEASED (Type or print) First William Middle John Last Foster		4. DATE OF DEATH Month June Day 29 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1880
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker- Retired		10b. KIND OF BUSINESS OR INDUSTRY Gen. Baking Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis Foster		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. ADDRESS Washington, DC		18. INFORMANT Wilbur A. Foster -14 Bryant St. N.W.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Ruptured Aneurysm of abdominal aorta Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause lost. generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-25 , 19 34 to 6-29 , 19 59 that I last saw the deceased alive on 6-26 , 19 59 , and that death occurred at 10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas W Harnsberger M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4201 New Hampshire 6/29/59	
PHYSICIAN'S NAME (Type) Chas. W. HARNSEBERGER		Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 7-2-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company-Washington, D.C.		24a. REC'D BY REGISTRAR JUL 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

1
X
I
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00010

CERTIFICATE OF DEATH

1942

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

Page 4
TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G244 7-8-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 215

6949

06920

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.R. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 834 Berkshire Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Commo FULLER		4. DATE OF DEATH Month Day Year 29 June 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 October 1895
9. AGE (In years last birthday) yrs. 63 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Vermont	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. COMMO		14. MOTHER'S MAIDEN NAME Ellen KINNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Stanley R. FULLER, YNC, USN RET Hyattsville, Md.		Address 834 Berkshire Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Antemortale Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 6 weeks? DUE TO (c) Generalized metastatic Carcinoma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14 , 19 59 , to June 29 , 19 59 that I last saw the deceased alive on June 29 , 19 59 , and that death occurred at 4:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED F. H. O'Connell U. S. Naval Hospital 29 June 59 ACTUAL SIGNATURE F. H. O'CONNELL M.D. U. S. Naval Hospital 29 June 59 PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT MC USN Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59	
22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Memorial		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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06921

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u>Smith</u> Last <u>Garsch</u>		4. DATE OF DEATH <u>June 4</u> 19 <u>59</u> Month <u>June</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1894</u> 65 yrs. 17 Months 7 Days 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales at Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Barnet Smith</u>		14. MOTHER'S MAIDEN NAME <u>unknown (Warsaw)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Sherry Garsch (husband)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Central pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior chest - Hemipleg</u> DUE TO <u>6 Hr.</u> (c) <u>Anterior chest - Hemipleg</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 58</u> , 19 <u>58</u> , to <u>6/4/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/4/59</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Kensington, Maryland</u> DATE SIGNED <u>6/4/59</u>	
ACTUAL SIGNATURE <u>Sam Allen</u>		M.D. <u>SAM ALLEN, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>Sam Allen, Kensington, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/5/59</u>		22b. DATE THEREOF <u>George Washington Medical School</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington, D. C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF BIRTH

State of Maryland

County of Prince George's

20th day of April 1882

born to the wife of

Charles H. Smith

at 124

Washington Street

(City of Washington)

Robert A. Humphrey

of

the County of Prince George's

do hereby certify that

27/2

Witness my hand and seal this 27th day of April 1882

Robert A. Humphrey

Medical Officer

Robert A. Humphrey, M.D.

CERTIFICATE OF DEATH

1931

<p>DECEASED</p>	
<p>NAME</p>	
<p>AGE</p>	
<p>SEX</p>	
<p>RACE</p>	
<p>DATE OF BIRTH</p>	
<p>DATE OF DEATH</p>	
<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>	
<p>IMMEDIATE CAUSE</p>	
<p>UNDERLYING CAUSE</p>	
<p>PERMANENT CAUSE</p>	
<p>DATE OF BURIAL</p>	
<p>PLACE OF BURIAL</p>	
<p>NAME OF BURIAL PLACE</p>	
<p>NAME OF MINISTER</p>	
<p>NAME OF CLERGYMAN</p>	
<p>NAME OF CHURCH</p>	
<p>NAME OF CEMETERY</p>	
<p>NAME OF FUNERAL HOME</p>	
<p>NAME OF UNDERTAKER</p>	
<p>NAME OF DRUGGIST</p>	
<p>NAME OF PHYSICIAN</p>	
<p>NAME OF NURSE</p>	
<p>NAME OF ATTORNEY</p>	
<p>NAME OF JUDGE</p>	
<p>NAME OF CLERK</p>	
<p>NAME OF SHERIFF</p>	
<p>NAME OF CONSTABLE</p>	
<p>NAME OF JURY</p>	
<p>NAME OF COURT</p>	
<p>NAME OF COUNTY</p>	
<p>NAME OF STATE</p>	

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6952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before/admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 32 km		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10962 Kenilworth Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jr.</u> Last <u>German</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-81</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>27</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Suburban Hosp</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John A. German</u>		14. MOTHER'S MAIDEN NAME <u>Roberta C. Allison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>577-46-9516</u>	
17. ADDRESS <u>Lottie E German Wife Same</u>		INFORMANT <u>Lottie E German</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>340.1</u> DUE TO <u>Pneumococcal meningitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO <u>48 hrs</u> (c) DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27, 1959</u> to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 27, 1959</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gump</u>		ADDRESS (Street, city or town, state) <u>Cherry Chase Drive 15 MD.</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gump Jr.</u>		DATE SIGNED <u>6/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>6/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Abbey Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital. The attending physician and coroner must sign the certificate. After the certificate has been signed by the attending physician and coroner, it should be filed with the funeral director. After the certificate has been signed by the attending physician and coroner, it should be filed with the funeral director. After the certificate has been signed by the attending physician and coroner, it should be filed with the funeral director.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1615-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>1417 Ruatan St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Winnifred</u> Middle <u>Adele</u> Last <u>Gibbons</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1925</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Vogt</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stombeck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Husband - 1417 Ruatan St. Hyattsville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <u>672X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured lower uterine muscle.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Term Pregnancy - Delivery</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 June, 1959</u> , to <u>11 June, 1959</u> , that I last saw the deceased alive on <u>11 June, 1959</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u>				ADDRESS (Street, city or town, state) <u>8801 Colesville Rd.</u>			
DATE SIGNED <u>6/11/59</u>							
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold Silver Spring, Md.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Luray, Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington 9, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>14008 THORNAPPLE STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Morris</u> First Middle Last <u>Hill</u>		4. DATE OF DEATH <u>6</u> / <u>25</u> / <u>1959</u> Month Day Year	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEON GUINSBURG</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE SCHLOSBERG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1898-1899</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>EPHRAIM JACOBS, 4008 THORNAPPLE ST., CH.CH., MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Posthypertensive Heart Disease</u> (c) <u>Sensitivity - a(7) 87yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>58</u> , to <u>6/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>59</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Kensington, Md.</u> DATE SIGNED <u>6/23/59</u>	
ACTUAL SIGNATURE <u>Sam Allen</u>		PHYSICIAN'S NAME (Type) <u>ALLEN</u> <u>KENSINGTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FORT MYER, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawler's Sons</u> ADDRESS <u>1756 Pa. Ave., N.W.</u>		24a. REC'D BY REGISTRAR <u>JUN 24 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

January 2, 1922

PLACE OF DEATH

St. James, Md.

NAME OF DECEASED

Marjorie Helen

SEX

Female

AGE

22

DATE OF BIRTH

Dec 22 1899

PLACE OF BIRTH

Russia

CAUSE OF DEATH

Ill

DIAGNOSIS

Ill

SIGNATURE OF PHYSICIAN

[Signature]

SIGNATURE OF REGISTRAR

[Signature]

DATE OF REGISTRATION

Jan 2 1922

PLACE OF REGISTRATION

St. James, Md.

NAME OF REGISTRAR

[Signature]

NAME OF PHYSICIAN

[Signature]

NAME OF DECEASED

Marjorie Helen

DATE OF DEATH

Jan 2 1922

PLACE OF DEATH

St. James, Md.

NAME OF REGISTRAR

[Signature]

NAME OF PHYSICIAN

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06926

6880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			c. LENGTH OF STAY IN 1b 17			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1111 HOLTON LANE				d. STREET ADDRESS 1111 HOLTON LANE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First HARRY		Middle L.		Last GOLD	
4. DATE OF DEATH		Month JUNE		Day 17		Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 1883		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT—RETIRED			10b. KIND OF BUSINESS OR INDUSTRY POLAND		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME MORRIS N. GOLD				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT DAVID GOLD 8603 BARRON ST., WASH., 12, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure and uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease + generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1957 , to June 17, 1959 , that I last saw the deceased alive on June 17, 1959 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2641 Colomille Rd. Silver Spring, Md. DATE SIGNED June 17, 1959							
ACTUAL SIGNATURE Blair H. Eig		M.D. Blair H. Eig, M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-19-59		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) HYATTSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS 3501 14th ST., N.W.				24a. REC'D BY REGISTRAR JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

6954 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 47X-3 d. STREET ADDRESS 1132 New Jersey Avenue, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Prentiss		First (none)		Middle Goodwin		4. DATE OF DEATH Month June Day 4, Year 19 59	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 25, 1936	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker				10b. KIND OF BUSINESS OR INDUSTRY Excavating		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Oran Goodwin				14. MOTHER'S MAIDEN NAME Amey Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 248-50-9265		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 133X DUE TO Arteriosclerosis and displacement of cerebellum - days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebellar abscess - occidodysentosis 6 mos (c) Pulmonary Occidodysentosis 4 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 15, 19 59 , to June 4, 19 59 , that I last saw the deceased alive on June 4, 19 59 , and that death occurred at 11:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 6/4/59 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Albert Treger M.D.				PHYSICIAN'S NAME (Type) ALBERT TREGER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 6-6-59		22c. NAME OF CEMETERY OR CREMATORY Hamlet N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Carnest Matthews				ADDRESS 3619-14th St. NW		24a. REC'D BY REGISTRAR DATE JUN 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kiser			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Age: <u>22</u></p>	
<p>5. Place of birth: <u>John Doe, Baltimore, Md.</u></p>		<p>6. Date of death: <u>Jan 1, 1922</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>John Doe, Baltimore, Md.</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Jan 1, 1922</u></p>		<p>12. Place of registration: <u>John Doe, Baltimore, Md.</u></p>	

1.
FOR STATE
HEALTH DEPT.

6955 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 8 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3505 FLORAL STREET			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 3505 FLORAL STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOSEPH Middle VINCENT Last GOUGH JR.			4. DATE OF DEATH Month JUNE Day 30 Year 19 59		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 4, 1916		9. AGE (In years last birthday) 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer (Mayflower Hotel)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME JOSEPH V. GOUGH, SR.			14. MOTHER'S MAIDEN NAME CATHERINE DOUGHERTY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #2 187-07-1883		17. INFORMANT Address Mrs. Blanche T. Gough, 3505 Floral St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Found dead Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) in bed PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/30/59	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/3/59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	
				22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUL 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6956

Item 2 Film (G2) 11 7-8-59

CERTIFICATE OF DEATH

06929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hospital</u>				d. STREET ADDRESS <u>Route 3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Louise Gregg</u>				4. DATE OF DEATH Month Day Year <u>June 29 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 8 - 1925</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Carry E. Ricketts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>James M. Gregg Rt. 3 Mt. Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rt. Breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ben. metastases</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 MO.</u> <u>3 MO.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>18 March</u> , 1956, to <u>29 June</u> , 1959, that I last saw the deceased alive on <u>29 June</u> , 1959, and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Olney, Md.</u> DATE SIGNED <u>29 June 59</u>							
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.							
PHYSICIAN'S NAME (Type) <u>John B. Ziegler M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Echison Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ray W. Barber, Laytonville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF CORONER
14. SIGNATURE OF JURY
15. SIGNATURE OF JUDGE
16. SIGNATURE OF CLERK
17. SIGNATURE OF SHERIFF
18. SIGNATURE OF DEPUTY SHERIFF
19. SIGNATURE OF CONSTABLE
20. SIGNATURE OF DEPUTY CONSTABLE
21. SIGNATURE OF TOWNSHIP CLERK
22. SIGNATURE OF COUNTY CLERK
23. SIGNATURE OF STATE CLERK
24. SIGNATURE OF SECRETARY OF HEALTH
25. SIGNATURE OF ASSISTANT SECRETARY OF HEALTH
26. SIGNATURE OF CHIEF CLERK
27. SIGNATURE OF DEPUTY CHIEF CLERK
28. SIGNATURE OF RECORDS CLERK
29. SIGNATURE OF INDEXING CLERK
30. SIGNATURE OF FILE CLERK
31. SIGNATURE OF DISTRIBUTION CLERK
32. SIGNATURE OF ARCHIVING CLERK
33. SIGNATURE OF PRESERVATION CLERK
34. SIGNATURE OF REPRODUCTION CLERK
35. SIGNATURE OF RELEASE CLERK
36. SIGNATURE OF REFERENCE CLERK
37. SIGNATURE OF RESEARCH CLERK
38. SIGNATURE OF ANALYSIS CLERK
39. SIGNATURE OF INTERPRETATION CLERK
40. SIGNATURE OF PRESENTATION CLERK
41. SIGNATURE OF EVALUATION CLERK
42. SIGNATURE OF MONITORING CLERK
43. SIGNATURE OF REPORTING CLERK
44. SIGNATURE OF COMMUNICATION CLERK
45. SIGNATURE OF OUTREACH CLERK
46. SIGNATURE OF EDUCATION CLERK
47. SIGNATURE OF PROMOTION CLERK
48. SIGNATURE OF PREVENTION CLERK
49. SIGNATURE OF PROTECTION CLERK
50. SIGNATURE OF POLICY CLERK
51. SIGNATURE OF PLANNING CLERK
52. SIGNATURE OF PROGRAM CLERK
53. SIGNATURE OF PROJECT CLERK
54. SIGNATURE OF PROCEDURE CLERK
55. SIGNATURE OF PROCESS CLERK
56. SIGNATURE OF PRODUCT CLERK
57. SIGNATURE OF PROJECT CLERK
58. SIGNATURE OF PROCEDURE CLERK
59. SIGNATURE OF PROCESS CLERK
60. SIGNATURE OF PRODUCT CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and taken to the funeral home as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06930

6881

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iakoma Park</u>	c. LENGTH OF STAY IN 1b <u>14 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>8712 Colesville Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Maude</u> Last <u>Grove</u>	4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-52</u>
9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Charles Timmons</u>	14. MOTHER'S MAIDEN NAME <u>Lucy Embrey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Hospital Records</u>	Address <u></u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Papillary adenocarcinoma bladder</u> DUE TO <u>5 years</u> (c) <u>Generalized metastases from Carcinoma Breast</u> DUE TO <u>3 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathological fracture Rt thigh due to bony metastases</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-10-59</u> to <u>6-15-59</u> , that I last saw the deceased alive on <u>6-16-59</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>W. C. Shoemaker</u> M.D.		PHYSICIAN'S NAME (Type) <u>N. C. Shoemaker, M.D.</u> <u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 Ga Anom</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>JUN 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanks</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

100330

File No.

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>15. SIGNATURE OF CORONER [Faint text]</p>		<p>16. SIGNATURE OF JURY [Faint text]</p>	
<p>17. SIGNATURE OF JURY [Faint text]</p>		<p>18. SIGNATURE OF JURY [Faint text]</p>	
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<p>91. SIGNATURE OF JURY [Faint text]</p>		<p>92. SIGNATURE OF JURY [Faint text]</p>	
<p>93. SIGNATURE OF JURY [Faint text]</p>		<p>94. SIGNATURE OF JURY [Faint text]</p>	
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<p>97. SIGNATURE OF JURY [Faint text]</p>		<p>98. SIGNATURE OF JURY [Faint text]</p>	
<p>99. SIGNATURE OF JURY [Faint text]</p>		<p>100. SIGNATURE OF JURY [Faint text]</p>	

101

6957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10401 Montrose Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN JAMES HAMILTON				4. DATE OF DEATH Month Day Year June 19 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days 10 16		IF UNDER 24 HRS. Hours Min. 10 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collection Manager				10b. KIND OF BUSINESS OR INDUSTRY R.L. Voight & Co		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME William Hamilton				14. MOTHER'S MAIDEN NAME ? Longley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 364-14-1887			
17. INFORMANT Lela J Hamilton-daughter-same as 2d				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Anemia, terminal DUE TO (b) carcinomatosis, widespread DUE TO (c) Carcinoma, Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH 4 days - 5 MONTHS 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BROCHITIS, CHRONIC							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 6/19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from OCT. 19 57 to 6/19 19 59 , that I last saw the deceased alive on 6/19 19 59 , and that death occurred at 08:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4890 BATTERY LANE DATE SIGNED 6/19/59 ACTUAL SIGNATURE Charles J. Savarese Jr. M.D. PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE JR. M.D. BETHESDA, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

REG. 001116

1. NAME OF DECEASED ROBERT J. HENRY		2. SEX MALE		3. AGE 32		4. DATE OF BIRTH 12/23/29		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 05/15/28		9. NAME OF SPOUSE JANE HENRY		10. ADDRESS 1001 HENRY AVENUE, BALTIMORE, MD.		11. CITY BALTIMORE		12. STATE MARYLAND	
13. CAUSE OF DEATH HEART DISEASE		14. PLACE OF DEATH HOME		15. DATE OF DEATH 01/15/32		16. TIME OF DEATH 10:30 AM		17. SIGNATURE OF PHYSICIAN J. HENRY		18. SIGNATURE OF REGISTRAR J. HENRY	
19. SIGNATURE OF DECEASED ROBERT J. HENRY		20. SIGNATURE OF WITNESS J. HENRY		21. SIGNATURE OF WITNESS J. HENRY		22. SIGNATURE OF WITNESS J. HENRY		23. SIGNATURE OF WITNESS J. HENRY		24. SIGNATURE OF WITNESS J. HENRY	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTEGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE KENTUCKY b. COUNTY PULASKI ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SOMERSET 55x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) 8604 Bradmoor Drive		d. STREET ADDRESS 110 COLLEGE STREET	
3. NAME OF DECEASED (Type or print) First Middle Last MAMIE (No middle name) HARGIS		4. DATE OF DEATH Month Day Year JUNE 29, 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R. HARRIS		14. MOTHER'S MAIDEN NAME NANCY JANE BULL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MRS. MARY L. SHORT 8604 BRADMOOR DR.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 DAYS 20 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MULTIPLE SCLEROSIS - 10 YEARS DURATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER, 1957 to JUNE 29, 1959 , that I last saw the deceased alive on JUNE 29, 1959 , and that death occurred at 10:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph D. Connor, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9420 Old Springtown Road Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 6/30/59	
22c. NAME OF CEMETERY OR CREMATORY Babbit Cemetery		22d. LOCATION (City, town, or county) (State) Mark, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR Awaiting PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of the certificate prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Bethesda</u> <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>35 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bruce</u> Middle <u>Tipton</u> Last <u>Heffley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1955</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Robert J. Heffley</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Lymphocytic Leukemia</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastrointestinal Hemorrhage</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>April 27, 1959</u> to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>June 1, 1959</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>HK Silberman</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6-2-59</u>			
PHYSICIAN'S NAME (Type) <u>Harold R. Silberman, M. D.</u>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6961

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 40 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edna Middle C Last Henshaw				4. DATE OF DEATH Month June Day 16 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13 1898	
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician				10b. KIND OF BUSINESS OR INDUSTRY Civil Serv. Com.			
11. BIRTHPLACE (State or foreign country) Green Bowling, Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wm. Ritter Carter				14. MOTHER'S MAIDEN NAME Imogene Hearn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. no			
17. INFORMANT Edmund L. Henshaw, Jr.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmaticus 241X DUE TO Branchial Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Branchial Asthma DUE TO (c) Branchial Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 24 hrs years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 5, 1959 to June 16, 1959 that I last saw the deceased alive on June 16, 1959 and that death occurred at 7:53 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Havell				DATE SIGNED 5516 Neb. Ave. - D.C. 6/16/59			
PHYSICIAN'S NAME (Type) Robert B. Havell				ADDRESS (Street, city or town, state) 5516 Neb. Ave., N.W. Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/59		22c. NAME OF CEMETERY OR CREMATORY Lakewood Cemetery		22d. LOCATION (City, town, or county) (State) Bowling Green, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR A DEDICATED PHYSICIAN: The low requires that the death certificate be executed within 24 hours after the death. The low requires that the death certificate be executed within 24 hours after the death. The low requires that the death certificate be executed within 24 hours after the death.

CERTIFICATE OF DEATH

1900

Deceased's Name

Age

Place of Birth

6898

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 76 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 North Van Buren St.		d. STREET ADDRESS 109 NORTH VAN BUREN	
3. NAME OF DECEASED (Type or print) ELIZABETH PUMPHREY HICKS		4. DATE OF DEATH JUNE 19 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 APRIL 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR — Months — Days — Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM REUBEN PUMPHREY		14. MOTHER'S MAIDEN NAME HARRIET AUGUSTA SHEKELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT J. R. Flewcharty		Address Cherry Chase Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 wks 25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Renal Calculus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19 49 to 19 June 1959 , that I last saw the deceased alive on 19 June 1959 , and that death occurred at 5:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W S Murphy		ADDRESS (Street, city or town, state) 615 W Montgomery Ave Rockville Maryland	
PHYSICIAN'S NAME (Type) W S MURPHY		DATE SIGNED 20 June 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUN 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thorne			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6962

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b XXXX.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES L. Middle HOCKENBERRY Last HOCKENBERRY		4. DATE OF DEATH Month June 13, Day 19 Year 59	
5. SEX Male XXXX	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1899
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 9 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Project Manager		10b. KIND OF BUSINESS OR INDUSTRY ICA	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert Bruce Hockenberry		14. MOTHER'S MAIDEN NAME Lottie Loudon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Wife Erma Hockenberry Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 hr. an 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While _____ of work <input type="checkbox"/> Not while _____ of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from July 17, 1957 to June 13, 1959 , that I last saw the deceased alive on June 13, 1959 , and that death occurred at 9 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Warren D. Brill, M.D.		ADDRESS (Street, city or town, state) 2601 - 16th St., N.W. DATE SIGNED 6-13-59	
PHYSICIAN'S NAME (Type) WARREN D. BRILL		Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-16-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	22d. LOCATION (City, town, or county) (State) Allentown, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Colbert L. Hume	

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Page 4

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The funeral director, after signing the certificate, should detach page 3 and deliver it to the funeral home or hospital. The funeral director, after signing the certificate, should detach page 3 and deliver it to the funeral home or hospital. The funeral director, after signing the certificate, should detach page 3 and deliver it to the funeral home or hospital.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6963

CERTIFICATE OF DEATH

06938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McLean d. STREET ADDRESS 5642 Cross Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Taylor Hoffman, Jr.		4. DATE OF DEATH Month June Day 26 , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1909
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 26 Hours 19 Min.	11. IF UNDER 24 HRS. Months 50 Days 26 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President		10b. KIND OF BUSINESS OR INDUSTRY Aviation Supply	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T. Hoffman		14. MOTHER'S MAIDEN NAME Catherine F. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-42-6661	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LUNG METASTASES - CARCINOMA DUE TO (c) CARCINOMA OF SOFT PALATE		INTERVAL BETWEEN ONSET AND DEATH 2 WKS 16 MOS 20 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE PANCREATITIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 19 59 , to June 26, 19 59 , that I last saw the deceased alive on June 26, 19 59 , and that death occurred at 12:40 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-26-59	
ACTUAL SIGNATURE Jack H. Bloch M.D.		National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Jack H. Bloch, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/29/59	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons		ADDRESS 1756 Pa. Ave., N.W. DC	
24a. REC'D BY REGISTRAR JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

238-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6964

CERTIFICATE OF DEATH

06939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>146 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Teresa</u> Last <u>Holland</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1898</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius D. Holland, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Alice Rachel Cruden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>389-09-1503</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, secondary to obstruction of</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Bladder</u> DUE TO (c) <u>urinary tract</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 12</u> , 19 <u>59</u> , to <u>June 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>59</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6/7/59</u> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>6-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOX LAKE CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>FOX LAKE, WISC.</u>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>WASH. D. C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS 3821 14TH. ST. N.W.				DATE <u>JUN 9 '59</u>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1917

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 45		DATE OF BIRTH Jan 15 1872	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE Nov 10 1905	
NAME OF WIFE Mary H. Harris		NAME OF CHILD(REN) John H. Harris	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH Dec 10 1917		TIME OF DEATH 10:30 A.M.	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	
SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 26		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Clagette Drive				d. STREET ADDRESS 1200 Clagette Drive				
3. NAME OF DECEASED (Type or print) First Mary Middle Ella Last HOLMES				4. DATE OF DEATH Month June Day 29 Year 19 59				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8, 1956 Jan. 27, 1954		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 5 Days 2	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Donald Holmes				14. MOTHER'S MAIDEN NAME Virginia Oakes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Donald Holmes - Same as Item #2 Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) congenital cardiac disease DUE TO (c) Marasmus								INTERVAL BETWEEN ONSET AND DEATH Birth to death
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from Jan 31, 1958 , to June 29, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 2:00 a.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED 6/29/59 ACTUAL SIGNATURE Richard M. Auld M.D. _____ PHYSICIAN'S NAME (Type) Richard M. Auld, M.D. 809 Viers Mill Rd. Rockville, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) _____ (State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

VS A15 (4)
S 5M 9/58

Robert A. Humphrey, Bethesda, Maryland

Serial 7/2/1952 Arlington National

Virginia

808 Vista Mill Rd, Rockville, Maryland

Richard M. And, M.D.

1951-1952

[Faint, illegible handwritten text]

None Donald Holmes-Saine as I am 43

Donald Holmes

Theresa Carter

None

Child

Mariland

USA

Famato White

Jan 20 1954

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Ellis

101-1112

1200 Classificative

1200 Classificative

Rockville

Rockville

Montgomery

Montgomery

Montgomery

DEPARTMENT OF HEALTH

6882

6882

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

074

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Certificate of Death									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>					4. DATE OF DEATH <u>June 2nd</u> 19 <u>59</u>				
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 2, 1959</u>		9. AGE (In years lost birthday) yrs. <u>1</u> <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Virgil Cleveland Hottinger</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Ann Frye</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <u>Informant</u>				
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Atelectasis</u> DUE TO (b) <u>Cause undetermined</u> DUE TO (c) <u>Polycystic kidneys</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polycystic kidneys</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June 2, 1959</u> , to <u>June 2, 1959</u> , that I last saw the deceased alive on <u>June 2, 1959</u> , and that death occurred at <u>6:55</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>W. C. Colliton, Jr.</u> M.D.					ADDRESS (Street, city or town, state) <u>809 View Mill Rd., Rockville, Md.</u>				
PHYSICIAN'S NAME (Type) <u>WILLIAM COLLITON JR. MD</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>June 4</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Redland Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber</u> <u>Seatonville, Md</u>					24a. REC'D BY REGISTRAR <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		

2074231XV2

1965

CERTIFICATE OF DEATH

Winfred
Bettie
Suburban
Road
1965

Winfred
Bettie
Suburban
Road
1965

Winfred Bettie
Suburban Road
1965

Winfred Bettie Suburban Road 1965

6966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens Nursing Home</u>		d. STREET ADDRESS <u>3140 University Blvd.-West</u>	
3. NAME OF DECEASED (Type or print) <u>Lucy Bloodworth Inabnett</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1876</u>
9. AGE (In years lost birth day) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt. - - - - -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis W. Bloodworth</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucy McColloch- Item #2 - daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pituitary Exhaustion</u> <u>153.8</u> DUE TO <u>Partial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal Obstruction, Malignancy Colon??</u> DUE TO (c) <u>Heart Block, Partial</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Wk</u> <u>10 Yrs plus</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>59</u> to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>6:40p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.		ADDRESS (Street, city or town, state) <u>10609 Concord St.</u> DATE SIGNED <u>June 1, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D. Kensington, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>6-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Griffin, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2, 4, 8, 9 Film G244 7-2-59 et

6882

CERTIFICATE OF DEATH

06943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 615 Roxboro Pl N.W. Takoma Park		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSPITAL.		d. STREET ADDRESS 615 Roxboro Place, N. TAKOMA PARK MD.	
3. NAME OF DECEASED (Type or print) ROSE EMMA First Middle Last		4. DATE OF DEATH June 26, 1959 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/29/88 1880
9. AGE (In years (last birthday)) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN L. DEAN		14. MOTHER'S MAIDEN NAME SOPHIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT EDWARD A JOHNSON		Address 615 ROXBORO PL N.W. HUSBAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 26, 1959 to June 26, 1959 , that I last saw the deceased alive on June 26, 1959 , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard L. Clays		ADDRESS (Street, city or town, state) 7600 Carroll Ave Takoma Park 6 26 59	
PHYSICIAN'S NAME (Type) Emd		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/30/59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM		22d. LOCATION (City, town, or county) (State) ARLINGTON VA	
23. FUNERAL DIRECTOR'S SIGNATURE W.K. HUNTEMANN & SON.		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
ADDRESS 5732 GEORGIA AVE N.W. WASHINGTON, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

WASHINGTON, D.C.

APR 10 1964

JOHN A. JOHNSON

WASHINGTON, D.C.

JOHN A. JOHNSON

JOHN A. JOHNSON

APR 10 1964

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JOHN A. JOHNSON

JOHN A. JOHNSON

JOHN A. JOHNSON

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6967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Northampton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 101 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape Charles		83 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 410 Washington Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles		Middle Seven		Last Kellam	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month June	
				B. DATE OF BIRTH September 23, 1932		9. AGE (In years last birthday) 26 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Virginia		IF UNDER 1 YEAR Months 26	
13. FATHER'S NAME Linwood Kellam		14. MOTHER'S MAIDEN NAME Etta M. Upshur		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 24 HRS. Days 20	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized reticulum cell sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March 11 , 19 59 , to June 20 , 19 59 , that I last saw the deceased alive on June 20 , 19 59 , and that death occurred at 3:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-21-59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE James M. Marsh		M.D.					
PHYSICIAN'S NAME (Type) James M. Marsh, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-25-59		22c. NAME OF CEMETERY OR CREMATORY New Allen Mem. Cem.		22d. LOCATION (City, town, or county) (State) FRANKTOWN VA	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, D.C.				24a. REC'D BY REGISTRAR JUN 25 '59		24b. REGISTRAR'S SIGNATURE Curtis S. Thomas	

TO HOSPITAL OR ATTEMPTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VS A1S (4)
ISM 10/S7

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2087

Name of Deceased [Illegible]		Sex [Illegible]		Race [Illegible]	
Date of Birth [Illegible]		Date of Death [Illegible]		Time of Death [Illegible]	
Place of Birth [Illegible]		Usual Residence [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]		Physician's Signature [Illegible]	
Burial Place [Illegible]		Burial Date [Illegible]		Burial Time [Illegible]	
Name of Burial Place [Illegible]		Name of Burial Officer [Illegible]		Signature of Burial Officer [Illegible]	
Name of Registrar [Illegible]		Signature of Registrar [Illegible]		Date of Registration [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6968

CERTIFICATE OF DEATH

06945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Jane Last Kinlaw				4. DATE OF DEATH Month June Day 12 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1927	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME William Burchfield				14. MOTHER'S MAIDEN NAME Etta Melcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rheumatic Heart Disease with Aortic and Mitral Stenosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 30 Minutes 7 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 10, 19 59 to June 12, 19 59 , that I last saw the deceased alive on June 12, 19 59 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jean Donald Wilson M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) JEAN DONALD WILSON, M.D.				DATE SIGNED 6-13-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-13-59				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY San Lorenza Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE C. E. King	
24a. REC'D BY REGISTRAR JUN 16 '59							

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Name of Deceased [Illegible]		Date of Death [Illegible]	
Sex [Illegible]		Age [Illegible]	
Usual Residence [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Physician's Signature [Illegible]		Medical Examiner's Signature [Illegible]	
Date of Report [Illegible]		Time of Report [Illegible]	
Registrar's Signature [Illegible]		Date of Registration [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6969

Item 22 Film 6243 6-15-59 et

CERTIFICATE OF DEATH

06946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>522 Beacon Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Davis</u> Last <u>Klaff</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1955</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey J. Klaff</u>		14. MOTHER'S MAIDEN NAME <u>Annette Koupchik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Clinical Center</u>		Address <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Malignancy</u> <u>197.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Mesenchymal Tumor</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>9 Months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 27, 1959</u> , to <u>June 7, 1959</u> , that I last saw the deceased alive on <u>June 7, 1959</u> , and that death occurred at <u>12:45 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6/7/59</u>			
ACTUAL SIGNATURE <u>H. R. Silberman</u> M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) <u>HAROLD R. SILBERMAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons - 3501 14th Street, N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 17101-New-Hampshire Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 17
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium

3. NAME OF DECEASED (Type or print) Nea O. Knight First Middle Last
4. DATE OF DEATH 6-16-1959 Month Day Year

5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 3/25/1897 9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
WIDOWED ☐ DIVORCED ☐ Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY at home 11. BIRTHPLACE (State or foreign country) Oskeola, Iowa 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Eastburn 14. MOTHER'S MAIDEN NAME Minnie Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none 16. SOCIAL SECURITY NO. none 17. INFORMATION Lloyd E. Knight Address above.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Failure -
416X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart disease -
DUE TO
(c) 20 yrs.

INTERVAL BETWEEN ONSET AND DEATH
3 mo -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/1, 1958, to June 16, 1959, that I last saw the deceased alive on June 16, 1959, and that death occurred at _____ M., from the causes and on the date stated above.

ACTUAL SIGNATURE Ernest A. Sarad M.D. ADDRESS (Street, city or town, state) 9006 New Hampshire Ave. DATE SIGNED 6/16/59
PHYSICIAN'S NAME (Type) ERNEST A. SARAD M.D. 7006 NEW HAMPSHIRE AVE

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6/16/59 22c. NAME OF CEMETERY OR CREMATORY National Memorial Park 22d. LOCATION (City, town, or county) (State) Falls Church, Va.

23. FUNERAL DIRECTOR'S SIGNATURE Kelley's Funeral Home, Inc. ADDRESS MT. Rainier Md. 24a. REGIS. BY REGISTRAR JUN 19 59 24b. REGISTRAR'S SIGNATURE Arthur S. Frank DATE JUN 19 59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6970

CERTIFICATE OF DEATH

06948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLANDER NURSING HOME				d. STREET ADDRESS 4852 Queen Chapel Terrace N.E.											
3. NAME OF DECEASED (Type or print) First NORMA Middle LAMBERT Last LAMBERT				4. DATE OF DEATH Month 6 Day 30 Year 19 59											
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1878		9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME --- Jarrett									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. no		INFORMANT Forrest Lambert-4852 Queen Chapel Terrace, N.E., Wash. DC									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 years															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/15, 1958 to 6/30, 1959 , that I last saw the deceased alive on 6/18, 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hamascus, Md. DATE SIGNED 6/30/59 ACTUAL SIGNATURE James P. Kerr M.D. PHYSICIAN'S NAME (Type) James P. Kerr															
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 7/1/59		22c. NAME OF CEMETERY OR CREMATORY Teays Hill Cemetery				22d. LOCATION (City, town, or county) (State) West Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.						24a. REC'D BY REGISTRAR DATE JUL 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

10000

CERTIFICATE OF DEATH

10000

4

INVESTIGATION REPORT

NAME: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF BIRTH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

REPORTED BY: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

6971

06949

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 56 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hulda Middle Mathilda Last LANGE				4. DATE OF DEATH Month June Day 9 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1863	9. AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ferdiand L. LANGE				14. MOTHER'S MAIDEN NAME Hulda WADAPHOHL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT (SON) George A. LANGE		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) atrial fibrillation Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 24 hr See above
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 April , 19 59 , to 9 June , 19 59 , that I last saw the deceased alive on 9 June , 19 59 , and that death occurred at 8:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE F. H. O'Connell LT MC USN				M.D. U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) F. H. O'CONNELL LT MC USN				U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-59		22c. NAME OF CEMETERY OR CREMATORY St. Boniface		22d. LOCATION (City, town, or county) (State) Meriden, Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY				ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR A MARRIED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00000

202

DECEASED

DECEASED

30 days

(month)

2755 Broadway Ave.

U.S. Naval Hospital, Bethesda Md.

DATE

DATE

DATE

DATE

January 12, 1903

January 12, 1903

January 12, 1903

Home

Home

Home

Home

Home

(son) George W. Davis

20

20

20

20

20

20

20

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Home

Home

Home

Home

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6972 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06950

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, NMMC				d. STREET ADDRESS 1101 S. Columbus Ave.			
3. NAME OF DECEASED (Type or print) First Gaye Middle (n) Last LANGELLO				4. DATE OF DEATH Month June Day 6 Year 19 59			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1917		9. AGE (in years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Newton SUBLETTE				14. MOTHER'S MAIDEN NAME Bonnie LANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT (Husband) Charles J. LANGELLO Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe necrotizing tracheitis and Bronchitis 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Etelectasis (bilateral) marked DUE TO (c) Inhalation of smoke						INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1st and 2nd degree burns involving extremities and trunk (7%)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported clothing caught afire while smoking in bed at home					
20c. TIME OF INJURY Month, Day, Year 6-1- 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Arlington		20g. (County) Arlington Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. BROSCHART				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	
22d. LOCATION (City, town, or county) Forest Glen Maryland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Murphy</i> ADDRESS 8424 Georgia Ave. Silver Spring Md				24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6974

Item 12 Film 6243 6-16-59 et

CERTIFICATE OF DEATH

06952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FERRUCCIO — LAZZARI</u>		4. DATE OF DEATH Month Day Year <u>JUNE 5 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/18</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>No Italy</u>	
13. FATHER'S NAME <u>FRANCESCO LAZZARI</u>		14. MOTHER'S MAIDEN NAME <u>Ferdinanda Rolfe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>210-32-5341</u>	
17. INFORMANT <u>Fred Lazzari</u>		Address <u>814 Forest Glen Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC STANDSTILL</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COMPLETE HEART BLOCK</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS INFARCTION</u> WITH MYO-CARDIAL INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>2 HRS</u> <u>17 YEARS</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 5</u> , 19 <u>59</u> , to <u>JUNE 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 5</u> , 19 <u>59</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 GEORGIA AVE.</u> DATE SIGNED ACTUAL SIGNATURE <u>Edward A. Beeman</u> M.D. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN, M.D.</u> <u>SILVER SPRING, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
ADDRESS <u>1400 Chapin St. N.W. Wash, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

0055

CERTIFICATE OF DEATH

0071

1

1. Name of deceased: *Robert J. Smith*

2. Date of death: *10/18/47*

3. Place of death: *Home*

4. Cause of death: *Heart failure*

5. Age at death: *68*

6. Sex: *Male*

7. Race: *White*

8. Marital status: *Married*

9. Occupation: *Teacher*

10. Signature of physician: *[Signature]*

11. Signature of registrar: *[Signature]*

12. Date of registration: *10/20/47*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6975

Item 1 Film 6244 7-7-59 at

CERTIFICATE OF DEATH

06953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		d. STREET ADDRESS <u>3710 Manor Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Walter</u> Last <u>Lewis</u>		4. DATE OF DEATH <u>June 27, 1959</u> Year <u>1959</u> Month <u>June</u> Day <u>27</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/1905</u>
9. AGE (In years last birthday) <u>54 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>4</u> Hours <u>15</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Real Estate Sals.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leonard H. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Lascellette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-7159</u>	
17. INFORMANT <u>Olga Lewis</u>		Address <u>Chevy Chase, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>1 1/2 hrs</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 26, 1959</u> , to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 26, 1959</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Humphrey, M.D.</u>		ADDRESS (Street, city or town, state) <u>1746 R St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Charles W. Humphrey, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newport News, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S H. Hines Co.</u>		ADDRESS <u>Washington, DC</u>	
24a. REC'D BY REGISTRAR <u>2901-14th St. N.W. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

1. *Chlorophyll a* and *Chlorophyll b* contents were determined by spectrophotometry using the method of Lichtenthaler and Whistler (1987).

[illegible]

6976

CERTIFICATE OF DEATH

06954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradley Hills Md. (Bethesda)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5704 Radnor Ct.</u>		d. STREET ADDRESS <u>5704 Radnor Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>Pauline</u> First <u>A.</u> Middle <u>Littell</u>		4. DATE OF DEATH <u>June</u> Month <u>12</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Seeger</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Hochner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William Ebe</u> Address <u>5704 Radnor Ct.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic Stenosis</u> DUE TO (c) <u>Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>60 Days</u> <u>60 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 2, 1957</u> to <u>June 12, 1959</u> , that I last saw the deceased alive on <u>June 12, 1959</u> , and that death occurred at <u>10 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John L. De Mayo M.D.</u>		ADDRESS (Street, city or town, state) <u>5632 Bradley Blvd. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John L. De Mayo</u>		DATE SIGNED <u>5632 Bradley Blvd. Bethesda Md.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>SHIP R.R.</u>	22b. DATE THEREOF <u>June 15, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BROOKLYN NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>		ADDRESS <u>3072 N. St. N.W.</u>	24a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>
		DATE <u>JUN 16 '59</u>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1920</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>10. OCCUPATION <i>Teacher</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. COLOR <i>White</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i></p>		<p>14. SIGNATURE OF REGISTRAR <i>W. B. Jones</i></p>		<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6977

CERTIFICATE OF DEATH

06955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alaska b. COUNTY Ketchikan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 105 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucinda Middle - Last MacDonald				4. DATE OF DEATH Month June Day 28 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1953	
9. AGE (In years last birthday) yrs. 5		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Alaska	
13. FATHER'S NAME Joseph MacDonald				14. MOTHER'S MAIDEN NAME Joanne O'Neil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 aplastic anemia DUE TO (b) Hemolytic crisis, 2nd to 6-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from March 15, 1959 to June 28, 1959 , that I last saw the deceased alive on June 28, 1959 , and that death occurred at 3:07 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Garren For				ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Leonard Garren, M. D.				DATE SIGNED 6-28-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Ketchikan Cemetery		22d. LOCATION (City, town, or county) (State) Ketchikan, Alaska	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO. N. W. Wash. D. C.				24a. REC'D BY REGISTRAR JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

100

2938473 W.W.

[Faint, illegible handwriting]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and taken to the burial-transit permit. Then please remove carbon page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6900

Item 2 FilmG243 6-15-59 et

CERTIFICATE OF DEATH

06956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville/ Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WAVERLY SANITARIUM		d. STREET ADDRESS 1200 Block 16th St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE First MADDUX Middle Last		4. DATE OF DEATH Month June Day 9 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/1859
9. AGE (In years last birthday) 99 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Maddux		14. MOTHER'S MAIDEN NAME Virginia Bartlett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Cabell Maddux		Address 4501 Chesterbrook Rd. McLean Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile weakness DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 72 hours 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22, 1959 , to June 9th 1959 , that I last saw the deceased alive on June 9th 1959 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE W.O. Huff ADDRESS (Street, city or town, state) Waverley Sanitarium DATE SIGNED 6/9/59 PHYSICIAN'S NAME (Type) W.O. Huff M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul		22d. LOCATION (City, town, or county) (State) Alexandria, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawrence Sons Inc.		24a. REC'D BY REGISTRAR DATE JUN 12 '59	
ADDRESS 1756 Pa. Ave. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE		COUNTY OF BALTIMORE CITY OF BALTIMORE	
NAME OF DECEASED MARY ANN BROWN		SEX FEMALE	
AGE 45		DATE OF BIRTH JAN 15 1875	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION SEWING	
CAUSE OF DEATH DISEASE OF THE HEART		PERIOD OF ILLNESS 10 DAYS	
PLACE OF DEATH HOME		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN W. C. HART		SIGNATURE OF WITNESS MARY ANN BROWN	
DATE JAN 20 1915		TIME 10:30 AM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director, and completed by the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
ISM 9/58

M

051

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2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
6978										
CERTIFICATE OF DEATH										
Reg. Dist. No. 215										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY St. Petersburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48X-3 d. STREET ADDRESS 6801 46th Ave. North e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Aron Middle MADSEN Last MADSEN					4. DATE OF DEATH Month June Day 28 Year 1959					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-99		9. AGE (In years last birthday) yrs. 60		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S.Coast Guard		11. BIRTHPLACE (State or foreign country) Denmark			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harold MADSEN					14. MOTHER'S MAIDEN NAME Ida MATTSON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. unknown		16. SOCIAL SECURITY NO. 066-30-6429			INFORMANT Hospital Records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, rectum, with metastases to liver and lungs. 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18 mos.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 7 , 19 59 , to June 28 , 19 59 , that I last saw the deceased alive on June 28 , 19 59 , and that death occurred at 10:20A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 6-29-59 ACTUAL SIGNATURE Matthew W. Wood M.D. PHYSICIAN'S NAME (Type) Matthew W. WOOD, LCDR, MC, USN Bethesda, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Shipment			22b. DATE THEREOF 6-29-59		22c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			22d. LOCATION (City, town, or county) (State) St. Petersburg Florida		
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey R. A. Humphrey Funeral Home, Bethesda, Md.					24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1937

U.S. DEPARTMENT OF HEALTH

(1937)

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and can be lawfully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6979 Item 9 Film G243 6-9-59 et									
CERTIFICATE OF DEATH									
Reg. Dist. No. 06958									
1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Tacoma Park 1617-2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 6817 Red Top Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Earl Last Manning					4. DATE OF DEATH Month June Day 1 Year 1959				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5 1901		9. AGE (In years last birthday) 58 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rhode Island			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Manning					14. MOTHER'S MAIDEN NAME Annie Dennis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW-1			16. SOCIAL SECURITY NO.		INFORMANT Ethel A. Manning (wife)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day 5+ years								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 20 April , 19 59 , to 1 June , 19 59 , that I last saw the deceased alive on 1 June , 19 59 , and that death occurred at 9:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE R. G. Galbraith M.D.									
PHYSICIAN'S NAME (Type) R. G. GALBRAITH LT MC USN					U. S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial			22b. DATE THEREOF 6-4-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home					ADDRESS 3072 M St. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House

70

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 18 Film 243 6-15-59
6980 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5123 Manning La</u>			d. STREET ADDRESS <u>5123 Manning La</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Georgia Taliaferro Marques</u>			4. DATE OF DEATH <u>June 9 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1916</u>		9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>	
13. FATHER'S NAME <u>Edmund Taliaferro</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>		
14. MOTHER'S MAIDEN NAME <u>Jane L. Colton</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>066-10-6267</u>			17. INFORMANT <u>Paul Marques (son)</u> Address <u>Stim 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 Fat embolism</u> DUE TO (b) <u>Fatty liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-10-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

STATE DEPT.
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1900

NAME OF DECEASED: John A. Smith
AGE: 45 YEARS
SEX: Male
DATE OF DEATH: Oct 15 1900
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
DISEASE OR INJURY: Myocarditis
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: John A. Smith
DATE: Oct 15 1900

1. Name of Deceased: John A. Smith
2. Age: 45
3. Sex: Male
4. Date of Death: Oct 15 1900
5. Place of Death: Home
6. Cause of Death: Heart Disease
7. Disease or Injury: Myocarditis
8. Manner of Death: Natural
9. Signature of Examiner: John A. Smith
10. Date: Oct 15 1900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE		c. LENGTH OF STAY IN lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 COPLEY LANE		d. STREET ADDRESS 505 COPLEY LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARJORIE C. MARSHALL		4. DATE OF DEATH Month JUNE Day 20 Year 19 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16, 1925	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Leroy Wright Chamberlain		14. MOTHER'S MAIDEN NAME Hulda Wirtaen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 517-24-1732		17. INFORMANT Mr. Robert C. Marshall, 505 Copley Lane, Colesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 272x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) secondary to pulmonary DUE TO (c) cardiomyopathy					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension & atherosclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from October 19, 1958 to June 20, 1959 , that I last saw the deceased alive on June 19, 1959 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2025 EWE ST NW DATE SIGNED ALFRED BRIGOLIO					
ACTUAL SIGNATURE ALFRED BRIGOLIO M.D.					
PHYSICIAN'S NAME (Type) ALFRED BRIGOLIO					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit & burial 6/25/59		22b. DATE THEREOF 6/25/59		22c. NAME OF CEMETERY OR CREMATORY Wolf Lake Village Cemetery	
22d. LOCATION (City, town, or county) Wolf Lake, Minnesota					
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond D. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 23 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma					

HOSPITAL OP. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

CERTIFICATE OF DEATH

40380

DEPARTMENT OF HEALTH
BALTIMORE, MD

NAME OF DECEASED JAMES M. JONES		SEX Male	
AGE 35		RACE White	
DATE OF BIRTH JAN 15 1932		PLACE OF BIRTH BALTIMORE, MD	
DATE OF DEATH JAN 15 1967		PLACE OF DEATH BALTIMORE, MD	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF WITNESS [Signature]	
ADDRESS OF DECEASED 1234 Main St, Baltimore, MD		ADDRESS OF NEXT OF KIN 5678 Oak St, Baltimore, MD	
OCCUPATION Teacher		EDUCATION High School Graduate	
MARITAL STATUS Single		RELIGION Protestant	
PREVIOUS ILLNESS None		MEDICAL HISTORY None	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF NEXT OF KIN [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6982

CERTIFICATE OF DEATH

06961

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			d. STREET ADDRESS <u>B.F. # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Itebbie</u> Middle <u>Ann</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1957</u>	9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Lloyd Martin</u>			14. MOTHER'S MAIDEN NAME <u>Mae Joyce</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>7730</u>		INFORMANT <u>Mae Martin</u> Address <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 7730 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hyaline Membrane Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>2 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 26</u> , 1959, to <u>June 30</u> , 1959, that I last saw the deceased alive on <u>June 29</u> , 1959, and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Mabel H. Browne</u>		ADDRESS (Street, city or town, state) <u>M.D. 2203 Irving Ave, N.W.</u> DATE SIGNED <u>6/30/59</u>			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	
				22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruben S. Snoroch</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

2

728

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06962

6983

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>15012 Flanders Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gertrude Agnes Martin</u>				4. DATE OF DEATH Month Day Year <u>June 15 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 8, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel David Butcher</u>				14. MOTHER'S MAIDEN NAME <u>Claudia Pierce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Jean Collison (daughter)</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma, type undetermined</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1953</u> , 19 <u></u> , to <u>date</u> , 19 <u></u> , that I last saw the deceased alive on <u>15 June</u> , 19 <u>59</u> , and that death occurred at <u>10:29 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Ball</u>				DATE SIGNED <u>June 15, 1959</u>			
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>				ADDRESS (Street, city or town, state) <u>Old Georgetown Rd Bethesda 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-trans.</u>		22b. DATE THEREOF <u>6-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Tree Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Corunna, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				ADDRESS <u></u>			
24a. REC'D BY REGISTRAR <u>JUN 17 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

074

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MEDICAL CERTIFICATION

0181-MA10011113

[Faint, mostly illegible text on a death certificate form. The form includes fields for name, date of birth, date of death, and cause of death. Some legible fragments include:]

[Name]
[Date of Birth]
[Date of Death]
[Cause of Death]

[Signature]
[Name]
[Title]

[Signature]
[Name]
[Title]

6984

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY 42x-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Victoria Middle Lee Last MARTIN				4. DATE OF DEATH Month June Day 25 Year 19 59			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-53	
9. AGE (In years last birthday) 5 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) California	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Richard Lee MARTIN			
14. MOTHER'S MAIDEN NAME Jeanette BOONE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT (F) Richard L. Martin, A03, USN Sta. Memphis, Tenn			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545 Congenital Heart Disease (Postoperative cardiac arrest) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 hrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 15 , 19 59 , to June 25 , 19 59 , that I last saw the deceased alive on June 25 , 19 59 , and that death occurred at 10:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 6-25-59							
ACTUAL SIGNATURE E. J. Rupnik				M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) E. J. RUPNIK, LCDR, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 6-26-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		22d. LOCATION (City, town, or county) (State) Monticello Arkansas	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR JUN 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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• *Journal of Management Education* 25(1): 10-12

6985

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE WASH. D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 1 yr.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. D.C. 47X-3				d. STREET ADDRESS 2811 PENNA. AVE. S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9301 Weaver Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE B. MATTARE				4. DATE OF DEATH Month Day Year JUNE 26 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1872	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min. 1 29		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Bernard Buscher				14. MOTHER'S MAIDEN NAME Louise Burkhardt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No/		16. SOCIAL SECURITY NO. None		17. INFORMANT Son Luke Mattare 5702 Kirkside Dr. Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) HYPERTENSIVE HEART DISEASE (c) AND DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH 2 MOS. 1 YEAR 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 29, 1959 to JUNE 26, 1959 , that I last saw the deceased alive on JUNE 26, 1959 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Vincent J. DiFrancesco				ADDRESS (Street, city or town, state) 2436 L'ENFANT SQUARE SE			
DATE SIGNED JUNE 26/1959							
PHYSICIAN'S NAME (Type) VINCENT J. DiFRANCESCO							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUL 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital for attending physician.

TO FUNERAL DIRECTOR: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06965

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9416 Locust Hill Rd</u>			d. STREET ADDRESS <u>9416 Locust Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Richard George May Jr</u>			4. DATE OF DEATH <u>June 2 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.
			IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kee Bus Asstt American RR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Richard Lee May</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ann Thomas</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>713-07-4180</u>		17. INFORMANT <u>Eleanor May (wife)</u> Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 2 1959</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Trans</u>		22b. DATE THEREOF <u>5/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tioga Point Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Athens, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6987

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
3. NAME OF DECEASED (Type or print) MILBURN XXXXXXXXXX		4. DATE OF DEATH Month June Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1880
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR 6 Months 22 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Leah McCarty-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x Acute Congestive Heart Failure DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Coronary Thrombosis Pulmonary Embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day unknown 2 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1959 , to June 15, 1959 , that I last saw the deceased alive on June 15, 1959 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James M. Loftus M.D.		ADDRESS (Street, city or town, state) 1673 Park Road N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) James M. Loftus		DATE SIGNED June 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6/16/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After a death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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Montgomery County Medical Examiner notified.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6989

CERTIFICATE OF DEATH

06968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Princess Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 128 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS Route #1, Box 15			
3. NAME OF DECEASED (Type or print) First Lawrence Middle (none) Last McMillion				4. DATE OF DEATH Month June Day 2, Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman				10b. KIND OF BUSINESS OR INDUSTRY Lumber Co.		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John McMillion				14. MOTHER'S MAIDEN NAME Liza Smithson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Blood Clot + Stomach Contents 292.3 DUE TO Gastro Intestinal tract Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) agranocytic myeloid metaplasia with (c) pancytopenia, myelofibrosis, hepatosplenomegaly 24 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 25, 1959 , to June 2, 1959 , that I last saw the deceased alive on June 2, 1959 , and that death occurred at 2:16 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman R. Gevirtz M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-2-59			
PHYSICIAN'S NAME (Type) Norman R. Gevirtz, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) Buried		22b. DATE THEREOF 6-5-59		22c. NAME OF CEMETERY OR CREMATORY Olive Branch		22d. LOCATION (City, town, or county) (State) Portsmouth, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				24a. REC'D BY REGISTRAR DATE JUN 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
CITY OF BALTIMORE [Illegible]		COUNTY OF BALTIMORE [Illegible]		STATE OF MARYLAND [Illegible]	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

6990

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06969

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Mt. Airy LENGTH OF STAY (in this place) 8 Years				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Mt. Airy STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Marian Groomes Meem				4. DATE OF DEATH (Month) (Day) (Year) June 6 19 59			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 7 1864	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. School Teacher			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hanson Groomes				14. MOTHER'S MAIDEN NAME Henretta Cashell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. No		17. INFORMANT & ADDRESS Virginia Groomes 2126 Conn. Ave. N.W. D.C.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 10 years	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/7 , 19 58 , to 6/6 , 19 59 , that I last saw the deceased alive on 6/3 , 19 59 , and that death occurred at MD , from the causes and on the date stated above. SIGNATURE [Signature] ADDRESS (Street, city, town, state) DAMASCUS MD 6/8/59 DATE SIGNED MD 6/8/59							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 9 59		NAME OF CEMETERY OR CREMATORY St. Johns		LOCATION (City, town, or county) (State) Olney Md.	
24. REC'D BY REGISTRAR DATE JUN 11 '59		REGISTRAR'S SIGNATURE Arthur S. Kline		25. FUNERAL DIRECTOR'S SIGNATURE Wayne Barber Laytonsville ADDRESS			

10088

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEPARTMENT OF HEALTH, BALTIMORE, MD.

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. RACE

7. OCCUPATION

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. SEX OF BIRTH

14. NAME OF FATHER

15. NAME OF MOTHER

16. NAME OF SPOUSE

17. NAME OF CHILD

18. NAME OF SIBLING

19. NAME OF NEAREST RELATIVE

20. NAME OF PHYSICIAN

21. NAME OF NURSE

22. NAME OF BURIAL

23. NAME OF INTERMENT

24. NAME OF FUNERAL HOME

25. NAME OF CEMETERY

26. NAME OF CHURCH

27. NAME OF MINISTERS

28. NAME OF PASTOR

29. NAME OF DEACON

30. NAME OF CHORUS

31. NAME OF ORGAN

32. NAME OF BAND

33. NAME OF ORCHESTRA

34. NAME OF THEATRE

35. NAME OF CIRCUS

36. NAME OF CARNIVAL

37. NAME OF FAIR

38. NAME OF EXHIBITION

39. NAME OF CONVENTION

40. NAME OF MEETING

41. NAME OF CONFERENCE

42. NAME OF SYMPOSIUM

43. NAME OF SEMINAR

44. NAME OF WORKSHOP

45. NAME OF COURSE

46. NAME OF PROGRAM

47. NAME OF LECTURE

48. NAME OF PAPER

49. NAME OF ARTICLE

50. NAME OF BOOK

51. NAME OF JOURNAL

52. NAME OF MAGAZINE

53. NAME OF NEWSPAPER

54. NAME OF PAMPHLET

55. NAME OF BROCHURE

56. NAME OF FLYER

57. NAME OF POSTER

58. NAME OF SIGN

59. NAME OF BANNER

60. NAME OF FLAG

61. NAME OF COAT OF ARMS

62. NAME OF SEAL

63. NAME OF MEDAL

64. NAME OF AWARD

1. This certificate is to be filled out by the attending physician or the coroner, and is to be signed by the physician or coroner, and the registrar, and the funeral director, and the undertaker, and the cemetery, and the church, and the minister, and the pastor, and the deacon, and the chorus, and the organ, and the band, and the orchestra, and the theatre, and the circus, and the carnival, and the fair, and the exhibition, and the convention, and the meeting, and the conference, and the symposium, and the seminar, and the workshop, and the course, and the program, and the lecture, and the paper, and the article, and the book, and the journal, and the magazine, and the newspaper, and the pamphlet, and the brochure, and the flyer, and the poster, and the sign, and the banner, and the flag, and the coat of arms, and the seal, and the medal, and the award.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6991

CERTIFICATE OF DEATH

06970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>3727 Jocelyn St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Jane</u> Last <u>Meyer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> , Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12 - 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Radnor, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Mather</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Barr</u> <u>Boise Idaho</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT (Son) <u>T.F. Meyer</u> <u>Boise Idaho</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-14-</u> , 19 <u>59</u> , to <u>6-14-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-14-</u> , 19 <u>59</u> , and that death occurred at <u>3:40</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.W. Bird</u>		M.D. <u>Sandy Spring</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>6/14/59</u>	
PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>THE S.H. HINES CO. 2901-14th St. N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6992 CERTIFICATE OF DEATH

06971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum 16 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		d. STREET ADDRESS 629 Sheridan St.	
3. NAME OF DECEASED (Type or print) First Susie Middle E. Last Meyers		4. DATE OF DEATH Month June Day 10 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/69
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Starr		14. MOTHER'S MAIDEN NAME Sarah J. Doxen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 Senility (age approx 90) (c) Partially Blind (90%)		INTERVAL BETWEEN ONSET AND DEATH yr yr yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/2/59 , 19, to 6/10/59 , 19, that I last saw the deceased alive on 6/9/59 , 19, and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE SAM ALLEN, M.D.		ADDRESS (Street, city or town, state) Kensington, Md. DATE SIGNED 6/10/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/13/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR JUN 12 1959	
ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

Montgomery County Medical Examiner notified.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6993					CERTIFICATE OF DEATH				
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.					d. STREET ADDRESS 3320 14th Place S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Scott Middle Alan Last MICHEALS					4. DATE OF DEATH Month June Day 12 Year 19 59				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 December 1958		9. AGE (In years last birthday) yrs. 6 Months 5 Days 5 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Warren R. MICHEALS					14. MOTHER'S MAIDEN NAME Joan KAPLIN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. INFORMANT		Address (Father) Warren R. MICHEALS Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Congenital Heart Disease - Aortic Stenosis, Mitral Regurgitation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mos 6 mos								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 28 May , 19 59 , to 12 June , 19 59 that I last saw the deceased alive on 12 June , 19 59 , and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED ACTUAL SIGNATURE Gerald I. Shugoll M.D. PHYSICIAN'S NAME (Type) Gerald I. SHUGOLL LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 6-13-59			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORY Mount Sharon		22d. LOCATION (City, town, or county) (State) Philadelphia, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey 1537 Wisconsin Ave. Bethesda Md.					24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Gerald I. Shugoll		

9VVVVVVVVVV

03330

CERTIFICATE OF DEATH

0333

State of Colorado

1930

(Year)

1930

U.S. Social Hospital, Bethesda Md.

Michaelis

John

George

7 December 1930

John

John

John

Philadelphia

John

John

John

ARTHUR N. MICHAELIS

(Father) Arthur N. MICHAELIS

Official Record: Jackson County, Colorado

Handwritten signature

George L. CHAPMAN, Jr. MD

John

John

U.S. Social Hospital, Bethesda Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Board of Health. TO FUNERAL DIRECTOR: Page 3 "could be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

6994 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Brookmont</u>		c. LENGTH OF STAY IN TB <u>15 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Solomon River</u>		e. STREET ADDRESS <u>2708 N Buchanan</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Burnham Milleken</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9 1942</u>
9. AGE (in years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEXAS-</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS-</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>C.B. Milleken</u>		14. MOTHER'S MAIDEN NAME <u> Evelyn Mackedon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>5072 Yakton Blvd</u>	
17. INFORMANT <u>Francis Hurst</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Choking</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Choking</u> DUE TO (c) <u>Choking</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Injured while swimming in Pot. R</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30 p.m.</u> <u>6-26</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pot. R.</u>		20f. (City or town) <u>N. Brookmont</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bruschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Bruschert</u> ADDRESS <u>2847 Wilson Blvd. Arlington</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

6884 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>2nd</u> b. COUNTY <u>Thos</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. STREET ADDRESS <u>2932 University Blvd.</u>			
3. NAME OF DECEASED (Type or print) <u>Infant boy</u> First Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-59</u>	
9. AGE (In years last-birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
		Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				<u>Takoma Park-Md.</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>Takoma Park-Md.</u>							
13. FATHER'S NAME <u>Hiram T. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Jordan Vaughn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Infant's chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-3</u> , 19 <u>59</u> , to <u>6-6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-6</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> p.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.				ADDRESS (Street, city or town, state) <u>8801 Coleville Road, Silver Spring, Md.</u>			
DATE SIGNED <u>6-6-59</u>							
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 7-1959</u>		<u>Big Stone Gap</u>		<u>Lee County Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u> ADDRESS <u>254 Carroll St.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE JUN 9 '59		<u>Chas. S. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed with the registrar as the burial-transit permit. Then please remove carbon page 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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D.E.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Page One of One

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. RACE White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. DATE OF DEATH 1955		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF DECEASED James E. Smith		17. SIGNATURE OF WITNESS John Doe		18. SIGNATURE OF PHYSICIAN Dr. John Doe		19. SIGNATURE OF CORONER John Doe		20. SIGNATURE OF REGISTRAR John Doe	
21. SIGNATURE OF DECEASED James E. Smith		22. SIGNATURE OF WITNESS John Doe		23. SIGNATURE OF PHYSICIAN Dr. John Doe		24. SIGNATURE OF CORONER John Doe		25. SIGNATURE OF REGISTRAR John Doe	
26. SIGNATURE OF DECEASED James E. Smith		27. SIGNATURE OF WITNESS John Doe		28. SIGNATURE OF PHYSICIAN Dr. John Doe		29. SIGNATURE OF CORONER John Doe		30. SIGNATURE OF REGISTRAR John Doe	
31. SIGNATURE OF DECEASED James E. Smith		32. SIGNATURE OF WITNESS John Doe		33. SIGNATURE OF PHYSICIAN Dr. John Doe		34. SIGNATURE OF CORONER John Doe		35. SIGNATURE OF REGISTRAR John Doe	
36. SIGNATURE OF DECEASED James E. Smith		37. SIGNATURE OF WITNESS John Doe		38. SIGNATURE OF PHYSICIAN Dr. John Doe		39. SIGNATURE OF CORONER John Doe		40. SIGNATURE OF REGISTRAR John Doe	
41. SIGNATURE OF DECEASED James E. Smith		42. SIGNATURE OF WITNESS John Doe		43. SIGNATURE OF PHYSICIAN Dr. John Doe		44. SIGNATURE OF CORONER John Doe		45. SIGNATURE OF REGISTRAR John Doe	
46. SIGNATURE OF DECEASED James E. Smith		47. SIGNATURE OF WITNESS John Doe		48. SIGNATURE OF PHYSICIAN Dr. John Doe		49. SIGNATURE OF CORONER John Doe		50. SIGNATURE OF REGISTRAR John Doe	
49. SIGNATURE OF DECEASED James E. Smith		50. SIGNATURE OF WITNESS John Doe		51. SIGNATURE OF PHYSICIAN Dr. John Doe		52. SIGNATURE OF CORONER John Doe		53. SIGNATURE OF REGISTRAR John Doe	
54. SIGNATURE OF DECEASED James E. Smith		55. SIGNATURE OF WITNESS John Doe		56. SIGNATURE OF PHYSICIAN Dr. John Doe		57. SIGNATURE OF CORONER John Doe		58. SIGNATURE OF REGISTRAR John Doe	
59. SIGNATURE OF DECEASED James E. Smith		60. SIGNATURE OF WITNESS John Doe		61. SIGNATURE OF PHYSICIAN Dr. John Doe		62. SIGNATURE OF CORONER John Doe		63. SIGNATURE OF REGISTRAR John Doe	
64. SIGNATURE OF DECEASED James E. Smith		65. SIGNATURE OF WITNESS John Doe		66. SIGNATURE OF PHYSICIAN Dr. John Doe		67. SIGNATURE OF CORONER John Doe		68. SIGNATURE OF REGISTRAR John Doe	
69. SIGNATURE OF DECEASED James E. Smith		70. SIGNATURE OF WITNESS John Doe		71. SIGNATURE OF PHYSICIAN Dr. John Doe		72. SIGNATURE OF CORONER John Doe		73. SIGNATURE OF REGISTRAR John Doe	
74. SIGNATURE OF DECEASED James E. Smith		75. SIGNATURE OF WITNESS John Doe		76. SIGNATURE OF PHYSICIAN Dr. John Doe		77. SIGNATURE OF CORONER John Doe		78. SIGNATURE OF REGISTRAR John Doe	
79. SIGNATURE OF DECEASED James E. Smith		80. SIGNATURE OF WITNESS John Doe		81. SIGNATURE OF PHYSICIAN Dr. John Doe		82. SIGNATURE OF CORONER John Doe		83. SIGNATURE OF REGISTRAR John Doe	
84. SIGNATURE OF DECEASED James E. Smith		85. SIGNATURE OF WITNESS John Doe		86. SIGNATURE OF PHYSICIAN Dr. John Doe		87. SIGNATURE OF CORONER John Doe		88. SIGNATURE OF REGISTRAR John Doe	
89. SIGNATURE OF DECEASED James E. Smith		90. SIGNATURE OF WITNESS John Doe		91. SIGNATURE OF PHYSICIAN Dr. John Doe		92. SIGNATURE OF CORONER John Doe		93. SIGNATURE OF REGISTRAR John Doe	
94. SIGNATURE OF DECEASED James E. Smith		95. SIGNATURE OF WITNESS John Doe		96. SIGNATURE OF PHYSICIAN Dr. John Doe		97. SIGNATURE OF CORONER John Doe		98. SIGNATURE OF REGISTRAR John Doe	
99. SIGNATURE OF DECEASED James E. Smith		100. SIGNATURE OF WITNESS John Doe		101. SIGNATURE OF PHYSICIAN Dr. John Doe		102. SIGNATURE OF CORONER John Doe		103. SIGNATURE OF REGISTRAR John Doe	

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6995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If residence before residence after death) a. STATE		Maryland		b. COUNTY		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		c. LENGTH OF STAY IN 1b		1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Suburban Hospital		d. STREET ADDRESS		7802 Marion Lane							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day	
MATILDA		E		MILLER				June		22		19 59	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		April 14, 1887		72		Months 2 Days 8 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Homemaker		Own Home		Wise, Virginia		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Robert Clark Vaughan		Susan Elizabeth Skeen											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address							
No		None		Son		Emory H Miller-2807 Byron St. Silver Sp.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH		1 hr.					
420.1		DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Coronary Occlusion		2 hr.							
		(c)		Hypertensive Cardiac Vascular Disease		10 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour o. m. p. m.		19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
21. I certify that I attended the deceased from		13 June		1959, to		22 June		1959, that I last saw the deceased alive on		22 June		1959, and that death occurred at	
		6 35 AM											
ACTUAL SIGNATURE		John B. Ball		M.D.		7936 Georgetown Rd.		DATE SIGNED					
PHYSICIAN'S NAME (Type)		John G. Ball											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)					
Burial		6/24/59		Parklawn Cemetery		Rockville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey		Bethesda, Maryland		DATE JUN 24 '59		Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo-</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1615-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>			d. STREET ADDRESS <u>7209 Forest Rd-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WARD</u> Middle <u>MILLER</u> Last <u>MILLER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L.C. Smith Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Columbia, New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Samuel MILLER</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service			16. SOCIAL SECURITY NO. <u>074-05-9382A</u> INFORMANT <u>Ward Miller, Jr.</u> <u>SON-8804</u> <u>meadist Bethesda-</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492X</u> DUE TO <u>pneumonitis, Rt. Middle Lobe</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>staphylococcus aureus</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 16, 1959</u> to <u>June 26, 1959</u> , that I last saw the deceased alive on <u>June 26, 1959</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Delwitt E. DeLauter, MD</u>			ADDRESS (Street, city or town, state) <u>8025 ABERDEEN Rd Bethesda Md.</u> DATE SIGNED <u>6/26/59</u>		
PHYSICIAN'S NAME (Type) <u>DELWITT E. DELAUTER</u>			8025 Aberdeen Rd. Beth. Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>7/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Iliom Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Iliom, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>			24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Kraus</u>

1100, New York

1100, New York

1100, New York

1100, New York

6997

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle Westfall Last Morse		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-73
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Newton Westfall		14. MOTHER'S MAIDEN NAME Lucinda Trimble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (D) Mrs. W.M. Silliphant, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissection of Aortic Aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 MIN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DOA , 19____, to____, 19____, that I last saw the deceased alive on____, 19____, and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 6-18-59			
ACTUAL SIGNATURE R. G. Muth		M.D. U. S. Naval Hospital	
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-20-59	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
ADDRESS R. A. Humphrey Funeral Home, Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Montgomery County Medical Examiner notified.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED JAN 10 1964

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE

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DISPATCH CENTER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6998

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>16 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2020 Marce Mill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>K.</u> Last <u>Moss</u>				4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 1867</u> yrs.	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles King</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Downs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Thelma Rogers</u> Address <u>20 E. Melbourne St. Silver Spring Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO <u>330X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured cerebral arterial aneurysm</u> DUE TO (c) <u>Congenital weakness of vascular wall</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>59</u> , to <u>June 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>59</u> , and that death occurred at <u>7</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D.				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>				DATE SIGNED			
22a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL</u>				ADDRESS <u>Home 4812 6th Ave</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100-000-100

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Date of Marriage	
13. Name of Physician		14. Name of Hospital		15. Name of Coroner		16. Name of Registrar	
17. Name of Undertaker		18. Name of Burial Place		19. Name of Cemetery		20. Name of Interment	
21. Name of Funeral Home		22. Name of Funeral Director		23. Name of Funeral Home		24. Name of Funeral Director	
25. Name of Funeral Home		26. Name of Funeral Director		27. Name of Funeral Home		28. Name of Funeral Director	
29. Name of Funeral Home		30. Name of Funeral Director		31. Name of Funeral Home		32. Name of Funeral Director	
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49. Name of Funeral Home		50. Name of Funeral Director		51. Name of Funeral Home		52. Name of Funeral Director	
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65. Name of Funeral Home		66. Name of Funeral Director		67. Name of Funeral Home		68. Name of Funeral Director	
69. Name of Funeral Home		70. Name of Funeral Director		71. Name of Funeral Home		72. Name of Funeral Director	
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97. Name of Funeral Home		98. Name of Funeral Director		99. Name of Funeral Home		100. Name of Funeral Director	

BOND

100-000-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 6 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, Inc.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAYTON d. STREET ADDRESS 13X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY GRACE MULLINX		4. DATE OF DEATH Month Day Year JUNE 1 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/88
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM MUSGROVE		14. MOTHER'S MAIDEN NAME CATHERINE CROOKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. York	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis with coronary sclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 46 , to June 1 19 59 , that I last saw the deceased alive on June 1 19 59 , and that death occurred at 1:17 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles S. Whitaker, M.D.		DATE SIGNED 6-1-59	
PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.		CLARKSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-4-59	22c. NAME OF CEMETERY OR CREMATORY Mt View	22d. LOCATION (City, town, or county) (State) Alpha, Howard Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Smith, Jr.		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
ADDRESS Clarksville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		ADDRESS OF REGISTRAR	
NAME OF PHYSICIAN		ADDRESS OF PHYSICIAN	
NAME OF WITNESS		ADDRESS OF WITNESS	
NAME OF SECOND WITNESS		ADDRESS OF SECOND WITNESS	
NAME OF THIRD WITNESS		ADDRESS OF THIRD WITNESS	
NAME OF FOURTH WITNESS		ADDRESS OF FOURTH WITNESS	
NAME OF FIFTH WITNESS		ADDRESS OF FIFTH WITNESS	
NAME OF SIXTH WITNESS		ADDRESS OF SIXTH WITNESS	
NAME OF SEVENTH WITNESS		ADDRESS OF SEVENTH WITNESS	
NAME OF EIGHTH WITNESS		ADDRESS OF EIGHTH WITNESS	
NAME OF NINTH WITNESS		ADDRESS OF NINTH WITNESS	
NAME OF TENTH WITNESS		ADDRESS OF TENTH WITNESS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7000

CERTIFICATE OF DEATH

06980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 58 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hollywood 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 404 South West 62nd Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Lavell Last Nelson			4. DATE OF DEATH Month June Day 9 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1934		9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Grady Nelson				14. MOTHER'S MAIDEN NAME Ira Graben			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 416-42-7905		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease - Total Anomaly of Pulmonary Veins (c) Post-Operative adrenal hyperplasia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12 , 19 59 , to June 9 , 19 59 , that I last saw the deceased alive on June 9 , 19 59 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon I. Goldberg M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Leon I. Goldberg, M. D.		DATE SIGNED 6/10/59					
22a. BURIAL, CREMATION, REMOVAL, SPECIES Burial-Transit		22b. DATE THEREOF 6/11/59		22c. NAME OF CEMETERY OR CREMATORY Jasper, Alabama		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon copy of the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Reg. Dist. No.

<p>1. Name of deceased: Robert A. Propoyne-Bethesda, Maryland</p>		<p>2. Date of death: June 1, 1953</p>	
<p>3. Place of death: Propoyne-Bethesda, Maryland</p>		<p>4. Age at death: 45 years</p>	
<p>5. Sex: Male</p>		<p>6. Race: White</p>	
<p>7. Marital status: Married</p>		<p>8. Occupation: Physician</p>	
<p>9. Cause of death: Heart - to give natural history as</p>		<p>10. Manner of death: Heart - to give natural history as</p>	
<p>11. Signature of physician: Propoyne-Bethesda, Maryland</p>		<p>12. Signature of registrar: Propoyne-Bethesda, Maryland</p>	
<p>13. Date of registration: June 1, 1953</p>		<p>14. Place of registration: Propoyne-Bethesda, Maryland</p>	

1 1 075 1 0 VS A15 (4) 15M 10/57 BP TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached from the burial-transit permit. Then please remove carbon pages from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 075 1 0 VS A15 (4) 15M 10/57 BP TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached from the burial-transit permit. Then please remove carbon pages from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6885 CERTIFICATE OF DEATH

08154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Newcomb				4. DATE OF DEATH Month Day Year June 28, 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1959		9. AGE (In years last birthday) yrs. 18	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James Edward Newcomb				14. MOTHER'S MAIDEN NAME Margaret Gayle Renfro			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address father same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 27 1/2 weeks gestation 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-27-59 , 19 59 , to 6-28-59 , 19 59 , that I last saw the deceased alive on 6-28-59 , 19 59 , and that death occurred at 8:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Emma Hughes		M.D. Washington Sanitarium & Hospital		ADDRESS (Street, city or town, state) Takoma Park, Maryland		DATE SIGNED Washington Sanitarium and Hospital	
PHYSICIAN'S NAME (Type) Emma Hughes, M.D.		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-29-59		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital, Takoma Park 12, Maryland				24b. REGISTRAR'S SIGNATURE 2075232XVI JUL 30 '59 Arthur L. Farris			

MD-124

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. Name of Deceased: *James A. [illegible]*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *1910*

5. Date of Death: *1955*

6. Place of Birth: *[illegible]*

7. Usual Residence: *[illegible]*

8. Cause of Death: *[illegible]*

9. Manner of Death: *[illegible]*

10. Signature of Physician: *[illegible]*

11. Signature of Registrar: *[illegible]*

12. Date of Registration: *[illegible]*

13. Place of Registration: *[illegible]*

14. Name of Hospital: *[illegible]*

15. Name of Doctor: *[illegible]*

16. Name of Nurse: *[illegible]*

17. Name of Undertaker: *[illegible]*

18. Name of Burial Place: *[illegible]*

19. Name of Interment: *[illegible]*

20. Name of Cemetery: *[illegible]*

21. Name of Church: *[illegible]*

22. Name of Minister: *[illegible]*

23. Name of Pastor: *[illegible]*

24. Name of Rector: *[illegible]*

25. Name of Priest: *[illegible]*

26. Name of Minister of the Gospel: *[illegible]*

27. Name of Minister of the Word: *[illegible]*

28. Name of Minister of the Sacrament: *[illegible]*

29. Name of Minister of the Eucharist: *[illegible]*

30. Name of Minister of the Communion: *[illegible]*

31. Name of Minister of the Holy Communion: *[illegible]*

32. Name of Minister of the Holy Eucharist: *[illegible]*

33. Name of Minister of the Holy Communion: *[illegible]*

34. Name of Minister of the Holy Eucharist: *[illegible]*

35. Name of Minister of the Holy Communion: *[illegible]*

36. Name of Minister of the Holy Eucharist: *[illegible]*

37. Name of Minister of the Holy Communion: *[illegible]*

38. Name of Minister of the Holy Eucharist: *[illegible]*

39. Name of Minister of the Holy Communion: *[illegible]*

40. Name of Minister of the Holy Eucharist: *[illegible]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

7001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06981

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>10417 Montrose Ave. - apt 102</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10417 Montrose Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Frank Dwing</u>		4. DATE OF DEATH <u>June 15 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1921</u> 37 yrs.
9. AGE (In years last birthday) <u>37</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>AEC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Claud Dwing</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Zeltman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Geraldine Dwing</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Subendocardial</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Boschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 15 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>San Francisco Cal</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest A. Adams</u>		ADDRESS <u>41748 Wad</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUN 18 '59</u>			

HEALTH DEPT
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1001

NAME OF DECEASED: John Doe

AGE: 45 SEX: Male

DATE OF DEATH: Jan 15 1918

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

DETAILS OF DEATH: Heart failure

SIGNATURE OF EXAMINER: [Signature]

DATE: Jan 15 1918

LOCATION: Baltimore

REGISTRATION NO.: 1001

FILE NO.: 1001

REMARKS: Heart failure

DATE OF BURIAL: Jan 16 1918

PLACE OF BURIAL: Home

SIGNATURE OF EXAMINER: [Signature]

DATE: Jan 16 1918

LOCATION: Baltimore

REGISTRATION NO.: 1001

FILE NO.: 1001

REMARKS: Heart failure

7002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D. O. A.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Loudoun</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sterling</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Geneva</u> Middle <u>Elizabeth</u> Last <u>Payne</u>			4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1926</u>		9. AGE (In years last birthday) <u>33</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>James Hawkins</u>			14. MOTHER'S MAIDEN NAME <u>Olivia Gantt</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-48-7833</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial obstruction of airway by blood</u> DUE TO <u>145.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive hemorrhage at site of (a) tonsil</u> DUE TO <u>Recurrent carcinoma @ tonsil</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>4 years</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>59</u> , to <u>June 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>59</u> , and that death occurred at <u>3:25 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Howard M. Radwin, M.D.</u>		The Clinical Center National Institutes of Health Bethesda 14, Maryland		6/29/59			
PHYSICIAN'S NAME (Type) <u>Howard M. Radwin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/1/1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mason</u>		ADDRESS <u>2500 Nichols Ave. S.E. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Fenn</u>		

MEDICAL CERTIFICATION

Examiner was not notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE NATURE OF DEATH: The nature of death in this patient had been followed in our outpatient clinic. Therefore, The Medical was not unexpected considering the primary diagnosis.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>36 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>Route 3, Box 227</u>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Arthur</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1922</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Arthur B. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Dollie Shawver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>234-20-5166</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>445 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UREMIA</u> DUE TO <u>MALIGNANT ARTERIOLAR NEPHROSCLEROSIS</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>DAYS</u> <u>Months</u> <u>months</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 21</u> , 19 <u>59</u> , to <u>June 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>59</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Oates, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6/27/59</u>			
PHYSICIAN'S NAME (Type) <u>John A. Oates, Jr., M.D.</u>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morris Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkview W. Va. Kanawha W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wisc. Ave. Bethesda Md</u>				24a. REG'D BY REGISTRAR DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Form 100-1

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1/1/1920		1/15/1965		Home		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Signature of informant		18. Signature of registrar		19. Signature of physician		20. Signature of registrar	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		Jane Doe		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
21. Name of funeral home		22. Address		23. City		24. State		25. Zip		26. Signature of funeral home		27. Signature of registrar		28. Signature of physician		29. Signature of registrar		30. Signature of physician	
Funeral Home		123 Main St		Baltimore		Maryland		21201		Funeral Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

RECEIVED
JAN 16 1965
BALTIMORE
M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7004 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>		c. LENGTH OF STAY IN 1b <u>5 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Black Hill Rd.</u>		d. STREET ADDRESS <u>Black Hill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>William Bryan Phillips Jr</u>		4. DATE OF DEATH <u>June 27 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3-1943</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm B. Phillips Sr</u>		14. MOTHER'S MAIDEN NAME <u>Albena Aholt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry Aholt - Son</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> <u>822X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest</u> (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of tractor while upset</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:55</u> p.m. <u>6-27-59</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>road</u>		20f. (City or town) <u>Boyd</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brachant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brachant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) <u>Leesburg Va</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Harris</u>	
ADDRESS <u>Barnesville, Md</u>		DATE <u>JUN 30 '59</u>	

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and taken to the funeral home as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14 Film G244 7-2-59 et

7005

CERTIFICATE OF DEATH

Reg. Dist. No.

06985

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Inn</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Everest</u> <u>Popper</u>		4. DATE OF DEATH Month Day Year <u>June</u> <u>17</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25-1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		9b. AGE (In years (last birthday) yrs. Months Days Hours Min. <u>75</u> <u>7</u> <u>3</u> <u>17</u> <u>59</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Vienna</u>	
13. FATHER'S NAME <u>Joseph Popper</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
14. MOTHER'S MAIDEN NAME <u>Sophia Pick</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-30-9796</u>		17. INFORMANT <u>R.C. Pollock</u> Address <u>4831-36 St. N.W., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of sigmoid colon, lung metastasis.</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> 19 <u>54</u> to <u>June 17</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 16</u> 19 <u>59</u> , and that death occurred at <u>4204</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew E. Rudnai</u> M.D.		ADDRESS (Street, city or town, state) <u>5120 MacArthur Blvd Wash, D.C.</u>	
DATE SIGNED <u>6/17/59</u>			
PHYSICIAN'S NAME (Type) <u>ANDREW E. RUDNAI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kruze</u>		ADDRESS <u>1756 Pennsylvania Ave</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kruze</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruze</u>	
DATE <u>JUN 22 '59</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained for the hospital or attending physician. TO FUNERAL DIRECTOR: After a death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7006

CERTIFICATE OF DEATH

06986
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSEMARY Middle ELIZABETH Last PRICE		4. DATE OF DEATH Month June Day 20 , Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1880
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Tabler		14. MOTHER'S MAIDEN NAME Emeline Leather	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. No	
INFORMANT Mr. G. Carve Price-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gen. Arteriosclerotic-Hypertensive Disease DUE TO (c) 5 years INTERVAL BETWEEN ONSET AND DEATH 15 min (Five)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to 30 June , 19 59 , that I last saw the deceased alive on 20 June , 19 59 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Gordon M. Smith M.D. Barnesville, Md DATE SIGNED 20 June 59 PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland		24a. REC'D BY REGISTRAR DATE JUN 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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CHURCH OF DEATH

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6886 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
c. LENGTH OF STAY IN 1b <i>8 days</i>		d. STREET ADDRESS <i>2705 Kirkwood Place (Kirkwood Gardens)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Margaret</i> Last <i>Prueitt</i>		4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-23-84</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR: Months <i>7</i> Days <i>15</i> Hours <i>15</i> Min. <i>15</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James H. Cook</i>		14. MOTHER'S MAIDEN NAME <i>GEORGIANNA COOMES</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Records -</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive arteriosclerotic heart disease</i> DUE TO (c) <i>10 years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 6</i> , 1959, to <i>June 15</i> , 1959, that I last saw the deceased alive on <i>June 14</i> , 1959, and that death occurred at <i>11:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wayne Glickfield</i>		ADDRESS (Street, city or town, state) <i>6826 Riggs Road, Hyattsville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>H. WAYNE GLICKFIELD M.D.</i>		DATE SIGNED <i>June 15/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6/18/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wash. Nat'l. Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Geo. County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> <i>Raymond A. Buba</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7007

Items 8, 9 Film G244 7-17-59 et

CERTIFICATE OF DEATH

06988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. Germantown</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lynwood</u> Middle <u>—</u> Last <u>Putnam</u>		4. DATE OF DEATH Month <u>13 June</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refrigeration</u>	
11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>—</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sawyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Leola Daniels Putnam</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Coronary Artery Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>2 wks</u> <u>6 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 May, 1959</u> , to <u>13 June, 1959</u> , that I last saw the deceased alive on <u>9 June, 1959</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u>		M.D. <u>11134 Georgia Ave</u> <u>Silver Spring, Md</u>	
PHYSICIAN'S NAME (Type) <u>Merton L. White</u>		DATE SIGNED <u>June 13, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manteo Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Manteo, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>316 E. Diamond Ave. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

2007

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF CHURCH</p>		<p>20. SIGNATURE OF OTHER</p>	

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

7008 Item 21 Film G243 6-9-59 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>81 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>4516 Traymore Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgia Christine Rafferty</u>		4. DATE OF DEATH Month Day Year <u>June 1, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1958</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1</u> <u>0</u> <u>0</u> <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph P. Rafferty</u>		14. MOTHER'S MAIDEN NAME <u>Angene George</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral Hemorrhage and</u> <u>2043</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastro-Intestinal Hemorrhage</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u> <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12</u> , 19 <u>59</u> , to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nathan S. Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
DATE SIGNED <u>6-2-59</u>			
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

and first

<p>1. Name of deceased: <i>Robert A. Thompson</i></p>		<p>2. Date of death: <i>June 12, 1932</i></p>	
<p>3. Place of death: <i>Home</i></p>		<p>4. Age: <i>61</i></p>	
<p>5. Sex: <i>Male</i></p>		<p>6. Race: <i>White</i></p>	
<p>7. Occupation: <i>Engineer</i></p>		<p>8. Cause of death: <i>Heart disease</i></p>	
<p>9. Immediate cause: <i>Myocardial infarction</i></p>		<p>10. Contributing cause: <i>None</i></p>	
<p>11. Physician: <i>Dr. J. H. Smith</i></p>		<p>12. Coroner: <i>John D. Jones</i></p>	
<p>13. Burial place: <i>St. John's Cemetery</i></p>		<p>14. Burial date: <i>June 15, 1932</i></p>	
<p>15. Signature of physician: <i>[Signature]</i></p>		<p>16. Signature of coroner: <i>[Signature]</i></p>	

18
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 5 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

6887 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days 14 1/2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>			1d. STREET ADDRESS <u>9314 Weaver St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Jack Michael Reamer</u>			4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Hebrew</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-47</u>		9. AGE (In years last birthday) <u>12 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>Sindey H Reamer</u>			14. MOTHER'S MAIDEN NAME <u>ANN Barkow</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Subdural Hemorrhage</u> 813X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral contusion</u> DUE TO (c) <u>Auto injury</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while riding bicycle</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>1:30</u> p.m. <u>6-13</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
				20f. (City or town) <u>Silver Spring Monty Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-17-59</u>		22b. DATE THEREOF <u>George Washington</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Golding Funeral Home</u>		ADDRESS <u>4217 9th NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7009

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 13. Film G-244 6/29/59.cac.

CERTIFICATE OF DEATH

06991

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDNOR				c. LENGTH OF STAY IN 1b 8 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDNOR		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle WATTS Last REDMAN				4. DATE OF DEATH Month JUNE Day 5 Year 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1874		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director			10b. KIND OF BUSINESS OR INDUSTRY Mortician		11. BIRTHPLACE (State or foreign country) ILLINOIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH SEYMOUR WICKHAM JAMES				14. MOTHER'S MAIDEN NAME NANCY THOMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Miss Edna E. Watts, Ednor, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lft Hemiplegia 450x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 days 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2/1/57 , 19 57 , to 6/5/59 , 19 59 , that I last saw the deceased alive on 6/5/59 , 19 59 , and that death occurred at 10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. W. BIRD M.D. Sandy Spring Md 6/6/59 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/8/59		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

7010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5860 Marbury Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5860 Marbury Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN R. REEVES First Middle Last		4. DATE OF DEATH June 1, 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1906
9. AGE (In years lost birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Fred W. Reeves	
14. MOTHER'S MAIDEN NAME Alice A. Alderman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 11	
16. SOCIAL SECURITY NO. None		17. INFORMANT Lucile B. Reeves- Item # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/24/1955 to 6/1/1959 that I last saw the deceased alive on 5/14/1959 , and that death occurred at 3A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6/1/59 DATE SIGNED ACTUAL SIGNATURE W. T. Joyce M.D. PHYSICIAN'S NAME (Type) W. T. Joyce 8106 Maple Ridge Road, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6/1/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. ADDRESS		24a. REC'D BY REGISTRAR JUN 2 '59 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital for attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

2016

Maryland

Maryland

Baltimore

5889 Maryland Road

1220 Maryland Road

H. REEVES

JOHN T.

July 7, 1908

White

MD

Washington, D.C.

Physician

Lawyer

Alice A. Alderman

Prod. W. Reeves

Laurie H. Reeves - Item 2

None

W. H. H.

1908 People's Bridge Road, Baltimore, Maryland

Maryland

Cecil Hall

Continuation of 2015

Robert A. Thompson - Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda 14, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9607 MONTGOMERY DRIVE</u>		d. STREET ADDRESS <u>9607 MONTGOMERY DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CORNELIUS</u> Last <u>REIDY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG-29, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOVT. GUARD</u>		12. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
13. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>JOHN CORNELIUS REIDY</u>		16. MOTHER'S MAIDEN NAME <u>MCMAHON</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		18. SOCIAL SECURITY NO. <u>215-38-6714</u>	
19. INFORMANT <u>MR. DAVID REIDY</u>		20. ADDRESS <u>9607 MONTGOMERY DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>422.1</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>5 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>AVICULAR FIBRILLATION; AORTIC STENOSIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>OCTOBER, 1954</u> to <u>JUNE 4, 1959</u> , that I last saw the deceased alive on <u>JUNE 4, 1959</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor, M.D.</u>		ADDRESS (Street, city or town, state) <u>9420 Old Georgetown Road</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR</u>		DATE SIGNED <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>6-8-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony Hanna</u>		ADDRESS <u>3831 Gae NW</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
DATE <u>JUN 10 '59</u>			

CERTIFICATE OF DEATH

1911

10043

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Date of Death		Jan 15 1911	
Place of Death		Home	
Cause of Death		Heart Disease	
Occupation		Farmer	
Residence		123 Main St	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Minister		[Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06994

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sanitarium and Hospital</u>		d. STREET ADDRESS <u>6612-24th Place</u>	
3. NAME OF DECEASED (Type or print) <u>Louis Jay Remington</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1882</u>
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		12. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown by informant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. records and 6612-24th pl.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-15-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the medical examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1

TO BE FILLED IN BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH THE INFORMATION REQUIRED.
TO BE FILLED IN BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH THE INFORMATION REQUIRED.
TO BE FILLED IN BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH THE INFORMATION REQUIRED.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1925

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: Dr. J. A. Smith

9. Signature of Physician: Dr. J. A. Smith

10. Signature of Coroner: Dr. J. A. Smith

11. Signature of Juror: Dr. J. A. Smith

12. Signature of Juror: Dr. J. A. Smith

13. Signature of Juror: Dr. J. A. Smith

14. Signature of Juror: Dr. J. A. Smith

15. Signature of Juror: Dr. J. A. Smith

16. Signature of Juror: Dr. J. A. Smith

17. Signature of Juror: Dr. J. A. Smith

18. Signature of Juror: Dr. J. A. Smith

19. Signature of Juror: Dr. J. A. Smith

20. Signature of Juror: Dr. J. A. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6889

CERTIFICATE OF DEATH

06995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>Since 2-3-57</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San. & Hosp</u>				d. STREET ADDRESS <u>1600 16th Street, N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>DR. Victor Bell RENCH</u>				4. DATE OF DEATH <u>June 5, 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. RENCH</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Bartlett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>unobtainable</u>			
17. INFORMANT <u>R. B. RENCH</u>				Address <u>3707 Benton St N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, viral</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophagus, severe obstructive as</u> DUE TO (c) <u>Acute Bacterial carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>We wish a post mortem</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 0 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>for 2 yrs, 1957 to 1959</u> that I last saw the deceased alive on <u>6/5/59</u> and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 Lindwood St NW Wash. DC</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Chas H. Wolcott</u>				PHYSICIAN'S NAME (Type) <u>Chas H. Wolcott</u>			
22a. BURIAL OR CREMATION. (Specify) <u>buried</u>		22b. DATE THEREOF <u>6/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos H. Hines Co</u>				ADDRESS <u>2901-14th St N.W.</u>		24a. REC'D BY REGISTRAR <u>DAWN 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles H. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-1-1910
JAMES M. BROWN
WHITE
MARRIED
BORN 10-1-1870
DIED 10-1-1910
CAUSE OF DEATH
HEART DISEASE
PLACE OF DEATH
HOME

NAME	JAMES M. BROWN
AGE	40
SEX	MALE
RACE	WHITE
MARRIAGE	MARRIED
BIRTH	10-1-1870
DEATH	10-1-1910
CAUSE OF DEATH	HEART DISEASE
PLACE OF DEATH	HOME
SIGNATURE	
DATE	

7012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood c. LENGTH OF STAY IN 1b 4 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6223 Kennedy Dr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kenwood d. STREET ADDRESS 6223 Kennedy Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fanny Middle Leigh Last Riley		4. DATE OF DEATH Month June Day 23 Year 19 59	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1867
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 92 Days 92 Hours 92 Min. 92	IF UNDER 24 HRS. Months 92 Days 92 Hours 92 Min. 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles H. Leigh	
14. MOTHER'S MAIDEN NAME Emily Adaline Poole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Mrs. Frances L. Denton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Bronchial) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis & Myocardial failure Chronic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 3rd, 1959 , to June 23, 1959 , that I lost saw the deceased alive on June 23, 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Marbury		ADDRESS (Street, city or town, state) 4545 Conn Ave NW DATE SIGNED 6/23/59	
PHYSICIAN'S NAME (Type) John B. Marbury		Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/59	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Lexington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons Inc. ADDRESS 1756 Pa. Ave. N.W. Washington D.C.		24a. REC'D BY REGISTRAR DATE JUN 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kears

Page 4

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
CERTIFICATE OF DEATH

2012

1

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

7013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND b. COUNTY 47X			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The District of Columbia			
c. LENGTH OF STAY IN 1b 10 days				d. STREET ADDRESS 3760 Foote Street, N. E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roy Middle Earl Last Rodney		4. DATE OF DEATH Month June Day 27 Year 1959					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1947	9. AGE (In years last birthday) yrs. 12	IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. 12	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert E. Rodney				14. MOTHER'S MAIDEN NAME Evelyn Scroggins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Bronchopneumonia DUE TO (b) Uremia DUE TO (c) Chronic Glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17, 1959 to June 27, 1959 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-28-59							
ACTUAL SIGNATURE Eugene B. Feigelson		M.D. The Clinical Center		National Institutes of Health		Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015				ADDRESS 12th St., N. E.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
				24b. REGISTRAR'S SIGNATURE C. S. K.			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. PLACE OF BIRTH [Illegible]</p>	
<p>10. OCCUPATION [Illegible]</p>		<p>11. EDUCATION [Illegible]</p>		<p>12. MARITAL STATUS [Illegible]</p>	
<p>13. PREVIOUS ILLNESS [Illegible]</p>		<p>14. MEDICAL HISTORY [Illegible]</p>		<p>15. PHYSICIAN'S SIGNATURE [Illegible Signature]</p>	
<p>16. CORONER'S SIGNATURE [Illegible Signature]</p>		<p>17. COUNTY CLERK'S SIGNATURE [Illegible Signature]</p>		<p>18. DATE OF FILING [Illegible]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7014 Item 19 Film G245 6-15-59 et
CERTIFICATE OF DEATH

06998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2348 North Early Street			
3. NAME OF DECEASED (Type or print) First James Middle Robert Last Rogers				4. DATE OF DEATH Month June Day 10 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 8, 1949	
				9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington	
13. FATHER'S NAME Robert O. Rogers				14. MOTHER'S MAIDEN NAME Sigrid Koski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Septicaemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) Acute Lymphatic Leukemia							INTERVAL BETWEEN ONSET AND DEATH 5 days 2 weeks 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 24, 1959 to June 10, 1959 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at 9:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathan S. Taylor				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/10/59			
PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/12/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. Arlington		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Demaine ADDRESS 1349				24a. REC'D BY REGISTRAR JUN 12 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

012

FILE NO.

NAME OF DECEASED JOHN J. JONES SEX M AGE 45 RACE W BIRTH 1900 PLACE OF BIRTH MD

DATE OF DEATH 1945 TIME OF DEATH 10:00 AM PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE NATURE OF DEATH NATURAL

IMMEDIATE CAUSE OF DEATH MYOCARDIAL INFARCTION

PREVAILING DISEASE HYPERTENSION

PREVAILING DISEASE ARTHRITIS

PREVAILING DISEASE DIABETES

PREVAILING DISEASE OBESITY

PREVAILING DISEASE SMOKING

PREVAILING DISEASE ALCOHOLISM

PREVAILING DISEASE OTHER

PREVAILING DISEASE UNKNOWN

PREVAILING DISEASE OTHER

PREVAILING DISEASE UNKNOWN

PREVAILING DISEASE OTHER

PREVAILING DISEASE UNKNOWN

PREVAILING DISEASE OTHER

PREVAILING DISEASE UNKNOWN

PREVAILING DISEASE OTHER

PREVAILING DISEASE UNKNOWN

PREVAILING DISEASE OTHER

PREVAILING DISEASE UNKNOWN

1
H
M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6890

CERTIFICATE OF DEATH

06999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 Sycamore Ave. (nursing home)</u>		d. STREET ADDRESS <u>unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Roy</u> Last <u>Roman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. Roman</u>		14. MOTHER'S MAIDEN NAME <u>Emma Gregory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Rena R. Wailes - 110 St. Albans Way</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - Left Side</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized & Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August, 19 54</u> to <u>30 June, 19 59</u> , that I last saw the deceased alive on <u>24 June, 19 59</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u>		ADDRESS (Street, city or town, state) <u>8801 Colesville Road, Balto., Md.</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Maryland.</u>		DATE SIGNED <u>6/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>DATE 1 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

CERTIFICATE OF DEATH

Form 100-100

<p>1. Name of deceased: _____</p>	
<p>2. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. Date of birth: _____</p>	
<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>	
<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>	
<p>8. Signature of physician: _____</p>	
<p>9. Signature of registrar: _____</p>	
<p>10. Date of filing: _____</p>	

7015

CERTIFICATE OF DEATH

07000

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 71 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3701 Connecticut Ave., NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ellis Last SAFFORD		4. DATE OF DEATH Month June Day 17 Year 19 59		5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-08		9. AGE (In years lost birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William F. ELLIS		14. MOTHER'S MAIDEN NAME Katherine HAND		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 4244 to 10/45		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Ischemia (c) Coronary Artery obstruction		INTERVAL BETWEEN ONSET AND DEATH 3 seconds "		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 7 , 19 59 , to June 17 , 19 59 , that I last saw the deceased alive on June 17 , 19 59 , and that death occurred at 4:07 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 6-18-59													
ACTUAL SIGNATURE F. H. O'Connell		PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN		M.D. U. S. Naval Hospital		BETHESDA 14, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Virginia		23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS Washington, D.C.		24. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

051

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VS A15 (4)
15M 9/58

$$(2.11)$$

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

• **How to use this book**

7032-2-3494

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• *Journal of the American Medical Association*, 1997; 277: 1001-1005

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07001

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 14 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7901 Chelton Road		d. STREET ADDRESS 7901 Chelton Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WESLEY Middle IRVING Last SAUTER		4. DATE OF DEATH Month June Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (State or foreign country) Connecticut
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Irving Sauter		14. MOTHER'S MAIDEN NAME Anna W. Lake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-30-0941	17. INFORMANT Wesley S. Sauter, Jr
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 15 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/23/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE JUN 24 '59	
24b. REGISTRAR'S SIGNATURE Bethesda, Maryland		Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>58</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium, 5721 Grosvenor</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
f. STREET ADDRESS <u>12016 Centerhill Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice Welsh Sceery</u> First Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>March 12, 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Warren Rhode Island</u>	
13. FATHER'S NAME <u>James Welsh</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT Address <u>Son-Walter R. Sceery - above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia (years)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broscaut</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broscaut</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-trans</u>		22b. DATE THEREOF <u>6-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Benedict</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford, Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUN 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07003

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>29 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> X	
d. STREET ADDRESS <u>5506 Sonoma Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Albert</u> Last <u>Scheirer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1895</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Elmira, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James W. Scheirer</u>		14. MOTHER'S MAIDEN NAME <u>Clara Benton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>578-32-6016</u>	
INFORMANT <u>Miss Nellian Scheirer</u>		Address <u>5506 Sonoma Rd Bethesda, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure.</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Post. Myocardial Infarction</u> DUE TO (c) <u>40 hr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>38 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/29</u> 19 <u>59</u> to <u>6/30</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> 19 <u>59</u> , and that death occurred at <u>10:20</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. J. Brennan</u>		ADDRESS (Street, city or town, state) <u>Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>		DATE SIGNED <u>6/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>7/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>She S. Hines</u>		24a. REC'D BY REGISTRAR <u>2901-14th St. N.W.</u>	
DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Pages 1 and 2 should be filled with the information required for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required for use of the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
ISM 9/58

7019

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland- b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle W Last Schley		4. DATE OF DEATH Month June Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump operator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Engineers	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Maggie Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrest DUE TO (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 1/2 hour 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1958 to 6/23 , 19 59 , that I last saw the deceased alive on 6/23 , 19 59 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Y. Jagggers, Jr. M.D.		ADDRESS (Street, city or town, state) 5707 Wisconsin Ave. Chevy Chase 15, Md. DATE SIGNED 6/23/59	
PHYSICIAN'S NAME (Type) Frank Y. Jagggers, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/59	
22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 25 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>4308 Hewitt Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Benjamin</u> Last <u>Schrider</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asst. Sec. Chief. U.S. Gov't. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin F. Schrider</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXX XXXXX Annie McGuire</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jerome P. Schrider, 3706 Ralph Rd. Silver Spring Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a), stating the underlying cause lost. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>6/23/59</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> <u>Raymond A. Giska, mgr.</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in writing and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

07006

Reg. Dist. No.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington, DC 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Convalescent Home		d. STREET ADDRESS 7315-13th Street N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna M Scott		4. DATE OF DEATH Month June Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sebastian Toepfer		14. MOTHER'S MAIDEN NAME Anna Aschenbach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
INFORMANT William H. Scott		Address Wash, D.C. 7315 13th St. N.W.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 19 50 19 _____, to June 6, 19 59 that I last saw the deceased alive on June 5, 19 59 , and that death occurred at 2:35 P. M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 1841 Col Rd NW DATE SIGNED E. H. Aschenbach			
ACTUAL SIGNATURE E. H. Aschenbach		M.D. 1841 Col Rd NW	
PHYSICIAN'S NAME (Type) E. H. Aschenbach			
22a. BURIAL, CREMATION, REMOVAL 6/9/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR JUN 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

03000

2201 CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 22 Film 6243 6-15-59 et

CERTIFICATE OF DEATH

7021

07007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>DC.</u> <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4600 5th St. N.W.</u>	
c. LENGTH OF STAY IN 1b <u>8 WKS.</u>		d. STREET ADDRESS <u>GREEN'S NURSING HOME - 11432 6th Collesville Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREEN'S NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH ANN SEBASTIAN</u>		4. DATE OF DEATH Month Day Year <u>June 4 1959</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>19-051156</u>	
17. INFORMANT <u>Coie Kendrick</u>		Address <u>7606-23rd W Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ADENOCARCINOMA, COLON</u> DUE TO (c) <u>10 Mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>51</u> , to <u>June 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 1</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Brandes</u> M.D.		ADDRESS (Street, city or town, state) <u>400 W ST. NE - DC.</u> DATE SIGNED <u>JUNE, 59</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT BRANDES, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Inx Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mattingly's</u> ADDRESS <u>131 - 11th St., S. E., Wash., D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director, and in any event within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7022									
CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
07008									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 45 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 1609 30th St. S.E.				
3. NAME OF DECEASED (Type or print) First Adolph Middle (n) Last SEIDLER					4. DATE OF DEATH Month June Day 5 Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 November 1881		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps			10b. KIND OF BUSINESS OR INDUSTRY Government			11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William SEIDLER					14. MOTHER'S MAIDEN NAME Wilhelmina KOPLIN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 1900 to 1932				
15. INFORMANT (Wife) Nora P. SEIDLER					Address Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 min. yes 10 yrs									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 5 June , 19 59 , to 5 June , 19 59 that I last saw the deceased alive on 5 June , 19 59 , and that death occurred at 10:30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 6-559 ACTUAL SIGNATURE R.G. Galbraith M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) R.G. GALBRAITH LT MC USN U.S. Naval Hospital, NNMC, Bethesda, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June 9/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Lee's 4th and Massachusetts Ave N.W. Washington					24a. REC'D BY REGISTRAR D. JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Huns		

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Department of Health

Washington

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7023

CERTIFICATE OF DEATH

07009

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Wash. D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>				d. STREET ADDRESS <u>1612 Portal Drive N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Seligson</u> Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 21, 1884</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Julius Seligson</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca ---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>052-10-6446</u>		17. INFORMANT Address <u>Leo Seligson - 1612-Portal Dr. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Intestine, Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>153.8</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1958</u> , to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 29</u> , 1959, and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Isidore Shulman</u>				ADDRESS (Street, city or town, state) <u>915-19th St. N.W.</u> DATE SIGNED <u>6-30-59</u>			
PHYSICIAN'S NAME (Type) <u>ISIDORE SHULMAN</u>				WASH. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis & Sons - Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

7024

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 245 8-10-59 et

07010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Deer</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carol City</u> 48X-3	
c. LENGTH OF STAY IN 1b <u>2 wks</u>		d. STREET ADDRESS <u>3765 N.W. 176th St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>228 Shorey Rd</u> (Visitor in private home)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Swift Sherrill</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1883</u>
9. AGE (in years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1st Col U.S.A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Ala</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ida Legg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> WW # <u>1&2</u>		16. SOCIAL SECURITY NO. <u>218-24-0896</u>	
17. INFORMANT <u>Mable Sherrill (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary occlusion</u> (c) <u>Coronary occlusion</u> DUE TO <u>Coronary occlusion</u> cause lost. (c) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-3-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Biska</u>		24a. REC'D BY REGISTRAR ADDRESS <u>SILVER SPRING, MARYLAND</u> DATE <u>JUN 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7025									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07011									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>3907 MERTFORD ST</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>SIMPSON</u>					4. DATE OF DEATH Month <u>JUNE</u> Day <u>15</u> Year <u>1959</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 14 1959</u>		9. AGE (In years lost birthday) yrs. <u>5</u> <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JACKIE DEORA SIMPSON</u>					14. MOTHER'S MAIDEN NAME <u>ALICILIA OUTLAW</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MOTHER</u>			Address <u>SAME AS ABOVE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemolytic disease of the newborn</u> <u>770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 14</u> , 19 <u>59</u> , to <u>June 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>59</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.					ADDRESS (Street, city or town, state) <u>809 Views Mill Rd. Rockville, Md.</u> DATE SIGNED <u>6/15/59</u>				
PHYSICIAN'S NAME (Type) <u>JAMES S. STANTON MD</u>					ADDRESS <u>809 Views Mill Rd. Rockville, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Spring</u>			22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Shawden</u> ADDRESS <u>Rockville, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
ISM 9/58

7026

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>White</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-8-80</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>MaKojak</u>				14. MOTHER'S MAIDEN NAME <u>Willie Sewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
INFORMANT <u>Willie White Smith</u>				Address <u>4342 Bethesda Montgomery Ave</u>			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic hypertensive cardiovascular disease</u> (c) <u>—</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>59</u> , to <u>June 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. C. Buchanan</u>				M.D. <u>Note: This patient has been known to our office and under the care of my associate Dr. T. J. Abernethy for a number of years.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>			
22a. REMOVAL INFORMATION, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thomson, Ga. Cem.</u>		22d. LOCATION (City, town, or county) <u>Thomson, Georgia</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7027

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>9 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1908 GLEN ROSS ROAD.</u>				1 d. STREET ADDRESS <u>1908 GLEN ROSS ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>ELBERT</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1886</u>		9. AGE (In years last birthday) <u>72</u> XXX yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>		11. BIRTHPLACE (State or foreign country) <u>MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL SMITH.</u>				14. MOTHER'S MAIDEN NAME <u>LOTTIE CLIFT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE.</u>		INFORMANT <u>MRS. EVA SMITH</u>		Address <u>1908 GLEN ROSS RD. SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE AND MYOCARDIAL ISCHOMIA</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> <u>2 YEARS</u> <u>2 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT.</u> , 19 <u>54</u> , to <u>JUNE 5</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>JUNE 5</u> , 19 <u>59</u> , and that death occurred at <u>5:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVENUE</u> DATE SIGNED <u>JUNE 5, 1959</u>							
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D.				SILVER SPRING, MD.			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>JUN 9 59</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hume</u>	

MEDICAL CERTIFICATION

00013

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Place of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital by the attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7028

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMASCUS d. STREET ADDRESS RIDGE ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GRACE ELIZABETH SNAPP		4. DATE OF DEATH Month JUNE Day 1 Year 19 59					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/91	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 1 Days 19 Hours 59 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA			
13. FATHER'S NAME JAMES M. RUDASILL		14. MOTHER'S MAIDEN NAME IDA E. GRANBSTAFF		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT HOSPITAL RECORDS, Address OLNEY, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conjunctive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Years INTERVAL BETWEEN ONSET AND DEATH 10 days Years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 19 57 , to June 1 , 19 59 , that I last saw the deceased alive on June 1 , 19 59 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Jach Schumacher M.D. ADDRESS (Street, city or town, state) 185 Russell Ave. Gaithersburg, Md. 6-1-59 DATE SIGNED PHYSICIAN'S NAME (Type) J. SCHUMACHER, M. D. GAITHERSBURG, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.			
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 4 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7029

CERTIFICATE OF DEATH

07015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 29 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6, 03x-2 d. STREET ADDRESS 455 Old Home Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel Jacob Staup			4. DATE OF DEATH Month June Day 10 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1906		9. AGE (In years lost birthday) yrs. 53		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder & Plumber		10b. KIND OF BUSINESS OR INDUSTRY Maintenance		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Alex Staup				
14. MOTHER'S MAIDEN NAME Susan Wilson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				
16. SOCIAL SECURITY NO. 215-07-0929			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year + 6 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from May 12 , 19 59 , to June 10 , 19 59 , that I last saw the deceased alive on June 10 , 19 59 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur T. Teplitzky		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 6/10/59			
PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-1959		22c. NAME OF CEMETERY OR CREMATORY Balto. National			
22d. LOCATION (City, town, or county) (State) Balto. 15, Md.		24a. REC'D BY REGISTRAR Spring Byers 500 Pk. Hgts Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23. FUNERAL DIRECTOR'S SIGNATURE Spring Byers 500 Pk. Hgts Ave		ADDRESS Balto 15, Md.		DATE JUN 12 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1003

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BOILED

1

1003

7030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>8 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10617 ORDWAY DRIVE</u>				d. STREET ADDRESS <u>10617 ORDWAY DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>IRENE</u> Last <u>STEVENSON</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WM. A. SEWELL</u>				14. MOTHER'S MAIDEN NAME <u>EDNA WILLIAMSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>DALE STEVENSON AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PARKINSON DISEASE</u> <u>350X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>59</u> , to <u>JUNE 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 25</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVENUE</u> <u>6/25/59</u> PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> <u>SILVER SPRING, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

7031 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07017									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN Ib <u>8 1/2 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9714 DILSTON ROAD</u>					d. STREET ADDRESS <u>1 9714 DILSTON ROAD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES CLARENCE STORM</u>					4. DATE OF DEATH Month Day Year <u>JUNE 7 1959</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 3, 1916</u>		9. AGE (In years lost birthday) <u>43 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS SERVICE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS Company</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME (By ADOPTION) <u>STORM, FRANK</u>					14. MOTHER'S MAIDEN NAME (By ADOPTION) <u>UNKNOWN SHME STOTT</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>Aug 1954 to Nov 1945</u>					16. SOCIAL SECURITY NO. <u>577 16 1188</u>		INFORMANT <u>MRS. CHAS. STORM</u> Address <u>AS ABOVE.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>3 MONTHS</u> <u>6 MONTHS</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>FEB. 27</u> , 19 <u>59</u> , to <u>JUNE 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 7</u> , 19 <u>59</u> , and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVENUE</u> <u>JUNE 7, 1959</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> <u>SILVER SPRING, MD.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Ziska</u>					ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

07013

CERTIFICATE OF DEATH

703

DATE OF DEATH: _____

TIME OF DEATH: _____

PLACE OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

CAUSE OF DEATH: _____

IMMEDIATE CAUSE: _____

UNDERLYING CAUSE: _____

PERMANENT CAUSE: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

TIME OF DEATH: _____

PLACE OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

CAUSE OF DEATH: _____

IMMEDIATE CAUSE: _____

UNDERLYING CAUSE: _____

PERMANENT CAUSE: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

1

6892

CERTIFICATE OF DEATH

07018

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b <i>21 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>514 Tulip Ave</i>		d. STREET ADDRESS <i>514 Tulip Ave</i>	
3. NAME OF DECEASED (Type or print) <i>BURDETTE FRANKLIN SWAN</i>		4. DATE OF DEATH Month <i>6</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/8/1876</i>
9. AGE (In years lost birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR: Months <i>1</i> Days <i>4</i> Hours <i>19</i> Min. <i>59</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>upholsterer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>upholstering</i>	
11. BIRTHPLACE (State or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Franklin W. Swan</i>		14. MOTHER'S MAIDEN NAME <i>Huff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-44-3511</i>	
17. INFORMANT <i>Mr. J. F. Harrison</i>		Address <i>514 Tulip Ave, Takoma Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal bronchopneumonia</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Malnutrition</i> DUE TO (c) <i>Generalized arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 months</i> <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 17, 1959</i> , to <i>June 4, 1959</i> , that I last saw the deceased alive on <i>June 4, 1959</i> , and that death occurred at <i>10:40 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		ADDRESS (Street, city or town, state) <i>918 University Blvd. E., Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		DATE SIGNED <i>6/4/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 6, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woods Washington Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Canal St. NW, DC.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07019

7032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 Hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Jane Last Taylor		4. DATE OF DEATH Month June Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Mass.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Schofield		14. MOTHER'S MAIDEN NAME Harriet Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Ulysses Griffith		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute upper respiratory infection DUE TO (c) 1 2 to 15 hr		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis, bronchiectasis, hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to June 19 , 1959 , that I last saw the deceased alive on June 19 , 1959 , and that death occurred at 12:31 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Main Street DATE SIGNED 6/19/59	
ACTUAL SIGNATURE G. F. Meadors M.D.		PHYSICIAN'S NAME (Type) G. F. Meadors, M.D. Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 22	22c. NAME OF CEMETERY OR CREMATORY Dunmore	22d. LOCATION (City, town, or county) (State) Scranton Penn.
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 23 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00010

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN. 15, 1962	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL DISTRICT	
MD		DC	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
DATE		DATE	
JAN. 15, 1962		JAN. 15, 1962	

6893

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Monrovia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospt.</u>		d. STREET ADDRESS <u>1 Moxley Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>Tenly</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/9/91</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Albert Tenly</u>		14. MOTHER'S MAIDEN NAME <u>Schaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>579-05-1645</u>	
17. INFORMANT <u>Mrs. Ada L. Tenly, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, Rt.</u> <u>443X</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>59</u> , to <u>6/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/19</u> , 19 <u>59</u> , and that death occurred at <u>124 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Dean H. Hardin</u> M.D. <u>113 Carroll St. NW, Wash. D.C.</u> <u>6/20/59</u> PHYSICIAN'S NAME (Type) <u>DEAN H. HARDIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 23, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Purple, George County, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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Page One of Two

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>	
<p>6. MARITAL STATUS [REDACTED]</p>		<p>7. OCCUPATION [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>		<p>9. MANNER OF DEATH [REDACTED]</p>		<p>10. PLACE OF DEATH [REDACTED]</p>	
<p>11. DATE OF DEATH [REDACTED]</p>		<p>12. TIME OF DEATH [REDACTED]</p>		<p>13. SIGNATURE OF DECEASED [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>		<p>15. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>16. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>17. SIGNATURE OF CLERK [REDACTED]</p>		<p>18. SIGNATURE OF JUDGE [REDACTED]</p>		<p>19. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>20. SIGNATURE OF CORONER [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the attending physician has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 19 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9925 Markham Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert Enoch Thompson		4. DATE OF DEATH June 23 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/89
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Wash. Post Newspaper	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Thompson		14. MOTHER'S MAIDEN NAME EMILY WILDERMUTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 161-10-4150	
17. INFORMANT Mrs. Margie G. Thompson, 9925 Markham St. Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarct (old) DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6-7 mo INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 , to 23 June, 1959 , that I last saw the deceased alive on 21 June, 1959 , and that death occurred at 11:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9006 Colesville Rd., Silver Spring, Md. DATE SIGNED William D. Aud			
ACTUAL SIGNATURE William D. Aud M.D.		22. REMOVAL (Specify) TRANS. & BURIAL	
22b. DATE THEREOF 6/26/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cemetery	
22d. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania		23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPKIN, INC. Raymond E. Ziska ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JUN 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Boyd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>L</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Thompson, Elizabeth Ann</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-30-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>home keeping</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Lella - Ray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Eleanor B. King, Boyd, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile Dementia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 years</u> <u>4-10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>since</u> , 19 <u>55</u> , to <u>June-4-1959</u> , that I last saw the deceased alive on <u>June-2-</u> , 19 <u>59</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7-Brooks ave., Gaithersburg, Md</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.			
PHYSICIAN'S NAME (Type) <u>William C. MILLER</u> <u>Gaithersburg, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knaus</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Knaus</u> DATE <u>JUN 9 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11592

CERTIFICATE OF DEATH

7034

NAME OF DECEASED <i>William C. Miller</i>		AGE <i>3 years</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>Aug. 3, 1902</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		RACE <i>White</i>	
OCCUPATION <i>None</i>		EDUCATION <i>None</i>		RELIGION <i>None</i>	
CAUSE OF DEATH <i>Infantile diphtheria</i>		PERIOD OF ILLNESS <i>2 weeks</i>		PLACE OF DEATH <i>Home</i>	
DATE OF DEATH <i>Aug. 27, 1904</i>		TIME OF DEATH <i>11:00 A.M.</i>		PLACE OF BURIAL <i>St. Paul's Church</i>	
NAME OF PHYSICIAN <i>Dr. J. B. Miller</i>		NAME OF FUNERAL HOME <i>None</i>		NAME OF MINISTER <i>None</i>	
NAME OF CORONER <i>None</i>		NAME OF JURY <i>None</i>		NAME OF WITNESSES <i>None</i>	
NAME OF REGISTRAR <i>None</i>		NAME OF CLERK <i>None</i>		NAME OF ASSISTANT CLERK <i>None</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and can be lawfully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07023

7035

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>352 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium-5721 Grosvenor Lane</u>				d. STREET ADDRESS <u>1324 Farragut St N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Scott</u> Last <u>Tipton</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Alfred White</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Downing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Laughton - Mrs. Virginia Phelps - 6504 Worthington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 29, 1957</u> , to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 29, 1959</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>2500 Calver St., N.W.</u> DATE SIGNED <u>6/30/59</u> <u>Washington 8, D.C.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulina Sons Inc., 1756 Rock Creek Pk. NW</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital by the attending physician and completed by the funeral director. After completion, the certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After completion, the certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7036

CERTIFICATE OF DEATH

07024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>56</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>2324 Seminary Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>J.</u> Last <u>Trumpour</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 3, 1870</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick W. Trumpour</u>		14. MOTHER'S MAIDEN NAME <u>Laura Machey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Spanish Amer.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. William Davis, 2700 Southington Road</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Artery Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate; Pneumonia 10 days ago</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 June 1959</u> to <u>17 June 1959</u> , that I last saw the deceased alive on <u>14 June 1959</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11134 Georgia Ave Silver Spring, Md</u>		DATE SIGNED <u>17 June 59</u>	
PHYSICIAN'S NAME (Type) <u>Merton L. White</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>6/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 23 '59</u>	
ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

7031

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>John Doe, Maryland</i></p>	
<p>5. Date of death: <i>Jan 1, 1950</i></p>		<p>6. Place of death: <i>John Doe, Maryland</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Date of registration: <i>Jan 1, 1950</i></p>		<p>12. Place of registration: <i>John Doe, Maryland</i></p>	
<p>13. Signature of registrar: <i>John Doe</i></p>		<p>14. Signature of registrar: <i>John Doe</i></p>	
<p>15. Signature of registrar: <i>John Doe</i></p>		<p>16. Signature of registrar: <i>John Doe</i></p>	
<p>17. Signature of registrar: <i>John Doe</i></p>		<p>18. Signature of registrar: <i>John Doe</i></p>	
<p>19. Signature of registrar: <i>John Doe</i></p>		<p>20. Signature of registrar: <i>John Doe</i></p>	
<p>21. Signature of registrar: <i>John Doe</i></p>		<p>22. Signature of registrar: <i>John Doe</i></p>	
<p>23. Signature of registrar: <i>John Doe</i></p>		<p>24. Signature of registrar: <i>John Doe</i></p>	
<p>25. Signature of registrar: <i>John Doe</i></p>		<p>26. Signature of registrar: <i>John Doe</i></p>	
<p>27. Signature of registrar: <i>John Doe</i></p>		<p>28. Signature of registrar: <i>John Doe</i></p>	
<p>29. Signature of registrar: <i>John Doe</i></p>		<p>30. Signature of registrar: <i>John Doe</i></p>	
<p>31. Signature of registrar: <i>John Doe</i></p>		<p>32. Signature of registrar: <i>John Doe</i></p>	
<p>33. Signature of registrar: <i>John Doe</i></p>		<p>34. Signature of registrar: <i>John Doe</i></p>	
<p>35. Signature of registrar: <i>John Doe</i></p>		<p>36. Signature of registrar: <i>John Doe</i></p>	
<p>37. Signature of registrar: <i>John Doe</i></p>		<p>38. Signature of registrar: <i>John Doe</i></p>	
<p>39. Signature of registrar: <i>John Doe</i></p>		<p>40. Signature of registrar: <i>John Doe</i></p>	
<p>41. Signature of registrar: <i>John Doe</i></p>		<p>42. Signature of registrar: <i>John Doe</i></p>	
<p>43. Signature of registrar: <i>John Doe</i></p>		<p>44. Signature of registrar: <i>John Doe</i></p>	
<p>45. Signature of registrar: <i>John Doe</i></p>		<p>46. Signature of registrar: <i>John Doe</i></p>	
<p>47. Signature of registrar: <i>John Doe</i></p>		<p>48. Signature of registrar: <i>John Doe</i></p>	
<p>49. Signature of registrar: <i>John Doe</i></p>		<p>50. Signature of registrar: <i>John Doe</i></p>	
<p>51. Signature of registrar: <i>John Doe</i></p>		<p>52. Signature of registrar: <i>John Doe</i></p>	
<p>53. Signature of registrar: <i>John Doe</i></p>		<p>54. Signature of registrar: <i>John Doe</i></p>	
<p>55. Signature of registrar: <i>John Doe</i></p>		<p>56. Signature of registrar: <i>John Doe</i></p>	
<p>57. Signature of registrar: <i>John Doe</i></p>		<p>58. Signature of registrar: <i>John Doe</i></p>	
<p>59. Signature of registrar: <i>John Doe</i></p>		<p>60. Signature of registrar: <i>John Doe</i></p>	
<p>61. Signature of registrar: <i>John Doe</i></p>		<p>62. Signature of registrar: <i>John Doe</i></p>	
<p>63. Signature of registrar: <i>John Doe</i></p>		<p>64. Signature of registrar: <i>John Doe</i></p>	
<p>65. Signature of registrar: <i>John Doe</i></p>		<p>66. Signature of registrar: <i>John Doe</i></p>	
<p>67. Signature of registrar: <i>John Doe</i></p>		<p>68. Signature of registrar: <i>John Doe</i></p>	
<p>69. Signature of registrar: <i>John Doe</i></p>		<p>70. Signature of registrar: <i>John Doe</i></p>	
<p>71. Signature of registrar: <i>John Doe</i></p>		<p>72. Signature of registrar: <i>John Doe</i></p>	
<p>73. Signature of registrar: <i>John Doe</i></p>		<p>74. Signature of registrar: <i>John Doe</i></p>	
<p>75. Signature of registrar: <i>John Doe</i></p>		<p>76. Signature of registrar: <i>John Doe</i></p>	
<p>77. Signature of registrar: <i>John Doe</i></p>		<p>78. Signature of registrar: <i>John Doe</i></p>	
<p>79. Signature of registrar: <i>John Doe</i></p>		<p>80. Signature of registrar: <i>John Doe</i></p>	
<p>81. Signature of registrar: <i>John Doe</i></p>		<p>82. Signature of registrar: <i>John Doe</i></p>	
<p>83. Signature of registrar: <i>John Doe</i></p>		<p>84. Signature of registrar: <i>John Doe</i></p>	
<p>85. Signature of registrar: <i>John Doe</i></p>		<p>86. Signature of registrar: <i>John Doe</i></p>	
<p>87. Signature of registrar: <i>John Doe</i></p>		<p>88. Signature of registrar: <i>John Doe</i></p>	
<p>89. Signature of registrar: <i>John Doe</i></p>		<p>90. Signature of registrar: <i>John Doe</i></p>	
<p>91. Signature of registrar: <i>John Doe</i></p>		<p>92. Signature of registrar: <i>John Doe</i></p>	
<p>93. Signature of registrar: <i>John Doe</i></p>		<p>94. Signature of registrar: <i>John Doe</i></p>	
<p>95. Signature of registrar: <i>John Doe</i></p>		<p>96. Signature of registrar: <i>John Doe</i></p>	
<p>97. Signature of registrar: <i>John Doe</i></p>		<p>98. Signature of registrar: <i>John Doe</i></p>	
<p>99. Signature of registrar: <i>John Doe</i></p>		<p>100. Signature of registrar: <i>John Doe</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6894

CERTIFICATE OF DEATH

Reg. Dist. No.

07025

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>1305 Merriman Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Jacob (NMN) Turetsky</u>		4. DATE OF DEATH <u>June 7 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Jewish</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Luggage worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Turetsky</u>		14. MOTHER'S MAIDEN NAME <u>ROSE SCHISMAN?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Sen. Raymond Turetsky - as above</u>	
17. INFORMANT <u>Same</u> Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY THROMBOSIS</u> cause (c), stating the underlying cause lost. (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE RHEUMATOID ARTHRITIS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>6/6</u> 19 <u>59</u> , to <u>6/7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/6</u> 19 <u>59</u> , and that death occurred at <u>4:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 9, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Station Island N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Wanzan</u> ADDRESS <u>3501-14th St. NW</u>		24a. REC'D BY REGISTRAR <u>June 9 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>		24c. DATE	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		DATE OF BIRTH [Faint handwritten date]	
PLACE OF BIRTH [Faint handwritten place]		OCCUPATION [Faint handwritten occupation]	
MARITAL STATUS [Faint handwritten status]		CAUSE OF DEATH [Faint handwritten cause]	
TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]	
DATE [Faint handwritten date]		TIME [Faint handwritten time]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health.

7037

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1300 HARDING LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PEARLE</u> Middle <u>N.</u> Last <u>TURNER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH HARDING</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE REYNOLDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>Mrs. Sterling Turner, 1304 Harding Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL GASTRIC CA. +</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED METASTASIS</u> DUE TO (c) <u>5 YRS</u> ONSET AND DEATH <u>Silver Spring, Md.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 JAN</u> , 19 <u>59</u> , to <u>5 JUNE</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 JUNE</u> , 19 <u>59</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>BLNEY, MD. JUNE 59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARDING ESTATE FAMILY CEMETERY, MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH MEMPHIS, TENNESSEE	
7. CAUSE OF DEATH MURDER		8. MANNER OF DEATH HOMICIDE		9. PLACE OF BIRTH MOBILE, ALABAMA	
10. OCCUPATION None		11. EDUCATION High School		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS MEDICATION None		20. PREVIOUS VACCINATIONS None		21. PREVIOUS X-RAYS None	
22. PREVIOUS PHYSICIAN None		23. PREVIOUS HOSPITALIZATION None		24. PREVIOUS AUTOPSY None	
25. PREVIOUS CORONER'S CASE None		26. PREVIOUS POLICE REPORT None		27. PREVIOUS FBI REPORT None	
28. PREVIOUS NEWSPAPER REPORT None		29. PREVIOUS RADIO REPORT None		30. PREVIOUS TELEVISION REPORT None	
31. PREVIOUS OTHER REPORT None		32. PREVIOUS OTHER INFORMATION None		33. PREVIOUS OTHER COMMENTS None	
34. PREVIOUS OTHER NOTES None		35. PREVIOUS OTHER RECORDS None		36. PREVIOUS OTHER FILES None	
37. PREVIOUS OTHER INDEXES None		38. PREVIOUS OTHER SEARCHES None		39. PREVIOUS OTHER RESULTS None	
40. PREVIOUS OTHER ACTIONS None		41. PREVIOUS OTHER DECISIONS None		42. PREVIOUS OTHER RECOMMENDATIONS None	
43. PREVIOUS OTHER SUGGESTIONS None		44. PREVIOUS OTHER ADVICE None		45. PREVIOUS OTHER OPINIONS None	
46. PREVIOUS OTHER COMMENTS None		47. PREVIOUS OTHER NOTES None		48. PREVIOUS OTHER RECORDS None	
49. PREVIOUS OTHER FILES None		50. PREVIOUS OTHER INDEXES None		51. PREVIOUS OTHER SEARCHES None	
52. PREVIOUS OTHER RESULTS None		53. PREVIOUS OTHER ACTIONS None		54. PREVIOUS OTHER DECISIONS None	
55. PREVIOUS OTHER RECOMMENDATIONS None		56. PREVIOUS OTHER SUGGESTIONS None		57. PREVIOUS OTHER ADVICE None	
58. PREVIOUS OTHER OPINIONS None		59. PREVIOUS OTHER COMMENTS None		60. PREVIOUS OTHER NOTES None	
61. PREVIOUS OTHER RECORDS None		62. PREVIOUS OTHER FILES None		63. PREVIOUS OTHER INDEXES None	
64. PREVIOUS OTHER SEARCHES None		65. PREVIOUS OTHER RESULTS None		66. PREVIOUS OTHER ACTIONS None	
67. PREVIOUS OTHER DECISIONS None		68. PREVIOUS OTHER RECOMMENDATIONS None		69. PREVIOUS OTHER SUGGESTIONS None	
70. PREVIOUS OTHER ADVICE None		71. PREVIOUS OTHER OPINIONS None		72. PREVIOUS OTHER COMMENTS None	
73. PREVIOUS OTHER NOTES None		74. PREVIOUS OTHER RECORDS None		75. PREVIOUS OTHER FILES None	
76. PREVIOUS OTHER INDEXES None		77. PREVIOUS OTHER SEARCHES None		78. PREVIOUS OTHER RESULTS None	
79. PREVIOUS OTHER ACTIONS None		80. PREVIOUS OTHER DECISIONS None		81. PREVIOUS OTHER RECOMMENDATIONS None	
82. PREVIOUS OTHER SUGGESTIONS None		83. PREVIOUS OTHER ADVICE None		84. PREVIOUS OTHER OPINIONS None	
85. PREVIOUS OTHER COMMENTS None		86. PREVIOUS OTHER NOTES None		87. PREVIOUS OTHER RECORDS None	
88. PREVIOUS OTHER FILES None		89. PREVIOUS OTHER INDEXES None		90. PREVIOUS OTHER SEARCHES None	
91. PREVIOUS OTHER RESULTS None		92. PREVIOUS OTHER ACTIONS None		93. PREVIOUS OTHER DECISIONS None	
94. PREVIOUS OTHER RECOMMENDATIONS None		95. PREVIOUS OTHER SUGGESTIONS None		96. PREVIOUS OTHER ADVICE None	
97. PREVIOUS OTHER OPINIONS None		98. PREVIOUS OTHER COMMENTS None		99. PREVIOUS OTHER NOTES None	
100. PREVIOUS OTHER RECORDS None		101. PREVIOUS OTHER FILES None		102. PREVIOUS OTHER INDEXES None	
103. PREVIOUS OTHER SEARCHES None		104. PREVIOUS OTHER RESULTS None		105. PREVIOUS OTHER ACTIONS None	
106. PREVIOUS OTHER DECISIONS None		107. PREVIOUS OTHER RECOMMENDATIONS None		108. PREVIOUS OTHER SUGGESTIONS None	
109. PREVIOUS OTHER ADVICE None		110. PREVIOUS OTHER OPINIONS None		111. PREVIOUS OTHER COMMENTS None	
112. PREVIOUS OTHER NOTES None		113. PREVIOUS OTHER RECORDS None		114. PREVIOUS OTHER FILES None	
115. PREVIOUS OTHER INDEXES None		116. PREVIOUS OTHER SEARCHES None		117. PREVIOUS OTHER RESULTS None	
118. PREVIOUS OTHER ACTIONS None		119. PREVIOUS OTHER DECISIONS None		120. PREVIOUS OTHER RECOMMENDATIONS None	
121. PREVIOUS OTHER SUGGESTIONS None		122. PREVIOUS OTHER ADVICE None		123. PREVIOUS OTHER OPINIONS None	
124. PREVIOUS OTHER COMMENTS None		125. PREVIOUS OTHER NOTES None		126. PREVIOUS OTHER RECORDS None	
127. PREVIOUS OTHER FILES None		128. PREVIOUS OTHER INDEXES None		129. PREVIOUS OTHER SEARCHES None	
130. PREVIOUS OTHER RESULTS None		131. PREVIOUS OTHER ACTIONS None		132. PREVIOUS OTHER DECISIONS None	
133. PREVIOUS OTHER RECOMMENDATIONS None		134. PREVIOUS OTHER SUGGESTIONS None		135. PREVIOUS OTHER ADVICE None	
136. PREVIOUS OTHER OPINIONS None		137. PREVIOUS OTHER COMMENTS None		138. PREVIOUS OTHER NOTES None	
139. PREVIOUS OTHER RECORDS None		140. PREVIOUS OTHER FILES None		141. PREVIOUS OTHER INDEXES None	
142. PREVIOUS OTHER SEARCHES None		143. PREVIOUS OTHER RESULTS None		144. PREVIOUS OTHER ACTIONS None	
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148. PREVIOUS OTHER ADVICE None		149. PREVIOUS OTHER OPINIONS None		150. PREVIOUS OTHER COMMENTS None	
151. PREVIOUS OTHER NOTES None		152. PREVIOUS OTHER RECORDS None		153. PREVIOUS OTHER FILES None	
154. PREVIOUS OTHER INDEXES None		155. PREVIOUS OTHER SEARCHES None		156. PREVIOUS OTHER RESULTS None	
157. PREVIOUS OTHER ACTIONS None		158. PREVIOUS OTHER DECISIONS None		159. PREVIOUS OTHER RECOMMENDATIONS None	
160. PREVIOUS OTHER SUGGESTIONS None		161. PREVIOUS OTHER ADVICE None		162. PREVIOUS OTHER OPINIONS None	
163. PREVIOUS OTHER COMMENTS None		164. PREVIOUS OTHER NOTES None		165. PREVIOUS OTHER RECORDS None	
166. PREVIOUS OTHER FILES None		167. PREVIOUS OTHER INDEXES None		168. PREVIOUS OTHER SEARCHES None	
169. PREVIOUS OTHER RESULTS None		170. PREVIOUS OTHER ACTIONS None		171. PREVIOUS OTHER DECISIONS None	
172. PREVIOUS OTHER RECOMMENDATIONS None		173. PREVIOUS OTHER SUGGESTIONS None		174. PREVIOUS OTHER ADVICE None	
175. PREVIOUS OTHER OPINIONS None		176. PREVIOUS OTHER COMMENTS None		177. PREVIOUS OTHER NOTES None	
178. PREVIOUS OTHER RECORDS None		179. PREVIOUS OTHER FILES None		180. PREVIOUS OTHER INDEXES None	
181. PREVIOUS OTHER SEARCHES None		182. PREVIOUS OTHER RESULTS None		183. PREVIOUS OTHER ACTIONS None	
184. PREVIOUS OTHER DECISIONS None		185. PREVIOUS OTHER RECOMMENDATIONS None		186. PREVIOUS OTHER SUGGESTIONS None	
187. PREVIOUS OTHER ADVICE None		188. PREVIOUS OTHER OPINIONS None		189. PREVIOUS OTHER COMMENTS None	
190. PREVIOUS OTHER NOTES None		191. PREVIOUS OTHER RECORDS None		192. PREVIOUS OTHER FILES None	
193. PREVIOUS OTHER INDEXES None		194. PREVIOUS OTHER SEARCHES None		195. PREVIOUS OTHER RESULTS None	
196. PREVIOUS OTHER ACTIONS None		197. PREVIOUS OTHER DECISIONS None		198. PREVIOUS OTHER RECOMMENDATIONS None	
199. PREVIOUS OTHER SUGGESTIONS None		200. PREVIOUS OTHER ADVICE None		201. PREVIOUS OTHER OPINIONS None	
202. PREVIOUS OTHER COMMENTS None		203. PREVIOUS OTHER NOTES None		204. PREVIOUS OTHER RECORDS None	
205. PREVIOUS OTHER FILES None		206. PREVIOUS OTHER INDEXES None		207. PREVIOUS OTHER SEARCHES None	
208. PREVIOUS OTHER RESULTS None		209. PREVIOUS OTHER ACTIONS None		210. PREVIOUS OTHER DECISIONS None	
211. PREVIOUS OTHER RECOMMENDATIONS None		212. PREVIOUS OTHER SUGGESTIONS None		213. PREVIOUS OTHER ADVICE None	
214. PREVIOUS OTHER OPINIONS None		215. PREVIOUS OTHER COMMENTS None		216. PREVIOUS OTHER NOTES None	
217. PREVIOUS OTHER RECORDS None		218. PREVIOUS OTHER FILES None		219. PREVIOUS OTHER INDEXES None	
220. PREVIOUS OTHER SEARCHES None		221. PREVIOUS OTHER RESULTS None		222. PREVIOUS OTHER ACTIONS None	
223. PREVIOUS OTHER DECISIONS None		224. PREVIOUS OTHER RECOMMENDATIONS None		225. PREVIOUS OTHER SUGGESTIONS None	
226. PREVIOUS OTHER ADVICE None		227. PREVIOUS OTHER OPINIONS None		228. PREVIOUS OTHER COMMENTS None	
229. PREVIOUS OTHER NOTES None		230. PREVIOUS OTHER RECORDS None		231. PREVIOUS OTHER FILES None	
232. PREVIOUS OTHER INDEXES None		233. PREVIOUS OTHER SEARCHES None		234. PREVIOUS OTHER RESULTS None	
235. PREVIOUS OTHER ACTIONS None		236. PREVIOUS OTHER DECISIONS None		237. PREVIOUS OTHER RECOMMENDATIONS None	
238. PREVIOUS OTHER SUGGESTIONS None		239. PREVIOUS OTHER ADVICE None		240. PREVIOUS OTHER OPINIONS None	
241. PREVIOUS OTHER COMMENTS None		242. PREVIOUS OTHER NOTES None		243. PREVIOUS OTHER RECORDS None	
244. PREVIOUS OTHER FILES None		245. PREVIOUS OTHER INDEXES None		246. PREVIOUS OTHER SEARCHES None	
247. PREVIOUS OTHER RESULTS None		248. PREVIOUS OTHER ACTIONS None		249. PREVIOUS OTHER DECISIONS None	
250. PREVIOUS OTHER RECOMMENDATIONS None		251. PREVIOUS OTHER SUGGESTIONS None		252. PREVIOUS OTHER ADVICE None	
253. PREVIOUS OTHER OPINIONS None		254. PREVIOUS OTHER COMMENTS None		255. PREVIOUS OTHER NOTES None	
256. PREVIOUS OTHER RECORDS None		257. PREVIOUS OTHER FILES None		258. PREVIOUS OTHER INDEXES None	
259. PREVIOUS OTHER SEARCHES None		260. PREVIOUS OTHER RESULTS None		261. PREVIOUS OTHER ACTIONS None	
262. PREVIOUS OTHER DECISIONS None		263. PREVIOUS OTHER RECOMMENDATIONS None		264. PREVIOUS OTHER SUGGESTIONS None	
265. PREVIOUS OTHER ADVICE None		266. PREVIOUS OTHER OPINIONS None		267. PREVIOUS OTHER COMMENTS None	
268. PREVIOUS OTHER NOTES None		269. PREVIOUS OTHER RECORDS None		270. PREVIOUS OTHER FILES None	
271. PREVIOUS OTHER INDEXES None		272. PREVIOUS OTHER SEARCHES None		273. PREVIOUS OTHER RESULTS None	
274. PREVIOUS OTHER ACTIONS None		275. PREVIOUS OTHER DECISIONS None		276. PREVIOUS OTHER RECOMMENDATIONS None	
277. PREVIOUS OTHER SUGGESTIONS None		278. PREVIOUS OTHER ADVICE None		279. PREVIOUS OTHER OPINIONS None	
280. PREVIOUS OTHER COMMENTS None		281. PREVIOUS OTHER NOTES None		282. PREVIOUS OTHER RECORDS None	
283. PREVIOUS OTHER FILES None		284. PREVIOUS OTHER INDEXES None		285. PREVIOUS OTHER SEARCHES None	
286. PREVIOUS OTHER RESULTS None		287. PREVIOUS OTHER ACTIONS None		288. PREVIOUS OTHER DECISIONS None	
289. PREVIOUS OTHER RECOMMENDATIONS None		290. PREVIOUS OTHER SUGGESTIONS None		291. PREVIOUS OTHER ADVICE None	
292. PREVIOUS OTHER OPINIONS None		293. PREVIOUS OTHER COMMENTS None		294. PREVIOUS OTHER NOTES None	
295. PREVIOUS OTHER RECORDS None		296. PREVIOUS OTHER FILES None		297. PREVIOUS OTHER INDEXES None	
298. PREVIOUS OTHER SEARCHES None		299. PREVIOUS OTHER RESULTS None		300. PREVIOUS OTHER ACTIONS None	

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07027

7038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write street and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4226 East-West Highway		d. STREET ADDRESS 4226 East-West Highway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD E. WENZEL		4. DATE OF DEATH Month Day Year June 25, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 0 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.-Naturalized	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-34-3566	
INFORMANT Wife		Address Same as Item #2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1958 , to June 1959 that I last saw the deceased alive on 24 June 1959 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 1746 - K St. N.W. Washington, D.C.	
ACTUAL SIGNATURE George W. Reeves		M.D. 1746 - K St. N.W. Washington, D.C.	
PHYSICIAN'S NAME (Type) GEORGE W. REEVES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

VS A15 (4)
15M 9/58

1033

COMMUNIST PARTY OF AMERICA

1033

Non-Communist

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6895

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Chetan</u> Last <u>Wheate</u>				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-09</u>	9. AGE (In years lost birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Analyst (retired) U.S. Air Force</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>James Wheate Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Beryl Dickelben</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of head of pancreas with</u> DUE TO <u>metastasis to liver and abdominal cavity</u> (c) <u>metastasis to liver and abdominal cavity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>12 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> 19 <u>56</u> , to <u>June 20</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 19</u> 19 <u>59</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md</u>		DATE SIGNED <u>6/20/59</u>	
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7039

CERTIFICATE OF DEATH

07029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>RESMOR SANITARIUM</u> <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>WASH. D.C.</u> <u>3122 LYNDAL PL. S.E.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u> <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR SANITARIUM</u>		d. STREET ADDRESS <u>3122 LYNDAL PL. S.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patrick J</u> First Middle Last		4. DATE OF DEATH <u>JUNE</u> Month Day Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 7, 1875</u> 84 yrs.
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGENT</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD WHITE</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA CONNORS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>YES-UNKNOWN</u>	
17. INFORMANT <u>ANNABELLE HARTMAN</u> Address <u>PITTSBURG, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE WITH METASTASIS</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery Heart Disease; Mild Diabetes.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 17, 1959</u> to <u>June 18, 1959</u> that I last saw the deceased alive on <u>June 17, 1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertram F. Schaefer</u>		ADDRESS (Street, city or town, state) <u>M.D. 1780 MASS - AVE. N.W. WASH D.C.</u>	
PHYSICIAN'S NAME (Type) <u>BERTAM F. SCHAEFER</u>		DATE SIGNED <u>June 18, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>WASH., D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan</u> ADDRESS <u>317 Penna</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07030			
7040										CERTIFICATE OF DEATH			
Reg. Dist. No. 215													
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia COUNTY Arlington								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 75 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					d. STREET ADDRESS 4334 N. Fairfax Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Edward Last WHITELEY					4. DATE OF DEATH Month June Day 26 Year 19 59								
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-85		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner					10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) South Dakota			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Winfield WHITELEY					14. MOTHER'S MAIDEN NAME Nancy HAWKINS								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WWI&II, Korean		INFORMANT Hospital Records					Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO generalized arterosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2) Chronic Pulmonary Emphysema DUE TO Chronic										INTERVAL BETWEEN ONSET AND DEATH 24-36 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Montgomery		(State) Maryland		
21. I certify that I attended the deceased from April 12 , 19 59 , to June 26 , 19 59 , that I last saw the deceased alive on June 26 , 19 59 , and that death occurred at 1:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 6-26-59 ACTUAL SIGNATURE Jerome A. Gold M.D. PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN Bethesda 14, Maryland													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6-30-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or county) Arlington			(State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Funeral Home, 517 11th St., SE						24a. REC'D BY REGISTRAR DATE JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht					

CERTIFICATE OF DEATH

(Name)

(Address)

(Occupation)

(Age)

(Sex)

(Cause of Death)

(Date of Death)

1

7041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 4, 22c & 22d Film G-244 6/19/59.c.

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 15 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 Granville Dr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring d. STREET ADDRESS 225 Granville Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Warner F. Wilckens First Middle Last		4. DATE OF DEATH June 13 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter--Statler Hotel		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Warner H. Wilckens		Address RFD # 3 Seaford, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had been dead several days when found			INTERVAL BETWEEN ONSET AND DEATH Found dead in bed
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16th	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery Oddfellow's Cemetery		22d. LOCATION (City, town, or county) (State) Seaford, Delaware Federalburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey Inc. ADDRESS 8434 Ga. Ave. SS. Md.		24a. REC'D BY REGISTRAR JUN 16 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur E. Hous	

STATE
DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
2011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. MARITAL STATUS		8. DATE OF BIRTH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF JURY		16. SIGNATURE OF CORONER	
17. SIGNATURE OF MEDICAL EXAMINER		18. SIGNATURE OF JURY	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
21. SIGNATURE OF MEDICAL EXAMINER		22. SIGNATURE OF JURY	
23. SIGNATURE OF CORONER		24. SIGNATURE OF JURY	
25. SIGNATURE OF MEDICAL EXAMINER		26. SIGNATURE OF JURY	
27. SIGNATURE OF CORONER		28. SIGNATURE OF JURY	
29. SIGNATURE OF MEDICAL EXAMINER		30. SIGNATURE OF JURY	
31. SIGNATURE OF CORONER		32. SIGNATURE OF JURY	
33. SIGNATURE OF MEDICAL EXAMINER		34. SIGNATURE OF JURY	
35. SIGNATURE OF CORONER		36. SIGNATURE OF JURY	
37. SIGNATURE OF MEDICAL EXAMINER		38. SIGNATURE OF JURY	
39. SIGNATURE OF CORONER		40. SIGNATURE OF JURY	
41. SIGNATURE OF MEDICAL EXAMINER		42. SIGNATURE OF JURY	
43. SIGNATURE OF CORONER		44. SIGNATURE OF JURY	
45. SIGNATURE OF MEDICAL EXAMINER		46. SIGNATURE OF JURY	
47. SIGNATURE OF CORONER		48. SIGNATURE OF JURY	
49. SIGNATURE OF MEDICAL EXAMINER		50. SIGNATURE OF JURY	
51. SIGNATURE OF CORONER		52. SIGNATURE OF JURY	
53. SIGNATURE OF MEDICAL EXAMINER		54. SIGNATURE OF JURY	
55. SIGNATURE OF CORONER		56. SIGNATURE OF JURY	
57. SIGNATURE OF MEDICAL EXAMINER		58. SIGNATURE OF JURY	
59. SIGNATURE OF CORONER		60. SIGNATURE OF JURY	
61. SIGNATURE OF MEDICAL EXAMINER		62. SIGNATURE OF JURY	
63. SIGNATURE OF CORONER		64. SIGNATURE OF JURY	
65. SIGNATURE OF MEDICAL EXAMINER		66. SIGNATURE OF JURY	
67. SIGNATURE OF CORONER		68. SIGNATURE OF JURY	
69. SIGNATURE OF MEDICAL EXAMINER		70. SIGNATURE OF JURY	
71. SIGNATURE OF CORONER		72. SIGNATURE OF JURY	
73. SIGNATURE OF MEDICAL EXAMINER		74. SIGNATURE OF JURY	
75. SIGNATURE OF CORONER		76. SIGNATURE OF JURY	
77. SIGNATURE OF MEDICAL EXAMINER		78. SIGNATURE OF JURY	
79. SIGNATURE OF CORONER		80. SIGNATURE OF JURY	
81. SIGNATURE OF MEDICAL EXAMINER		82. SIGNATURE OF JURY	
83. SIGNATURE OF CORONER		84. SIGNATURE OF JURY	
85. SIGNATURE OF MEDICAL EXAMINER		86. SIGNATURE OF JURY	
87. SIGNATURE OF CORONER		88. SIGNATURE OF JURY	
89. SIGNATURE OF MEDICAL EXAMINER		90. SIGNATURE OF JURY	
91. SIGNATURE OF CORONER		92. SIGNATURE OF JURY	
93. SIGNATURE OF MEDICAL EXAMINER		94. SIGNATURE OF JURY	
95. SIGNATURE OF CORONER		96. SIGNATURE OF JURY	
97. SIGNATURE OF MEDICAL EXAMINER		98. SIGNATURE OF JURY	
99. SIGNATURE OF CORONER		100. SIGNATURE OF JURY	

Weight - 2 lbs 13 oz

704 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>26</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>133 Moore Drive</u>			
3. NAME OF DECEASED (Type or print) <u>BABY GIRL WILLIAMS</u>				4. DATE OF DEATH <u>JUNE 17</u> 19 <u>59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 17 1959</u>	9. AGE (In years last birthday) yrs. <u>48</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD CALVIN WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE VIRGINIA GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>760.5</u> DUE TO <u>laceration, left leaf, tentorium cerebelli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity fetal atelectasis, Break delivery</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>Rockville, Md.</u>	(County) <u>—</u>	(State) <u>MD</u>		
21. I certify that I attended the deceased from <u>JUNE 17, 1959</u> , to <u>JUNE 17, 1959</u> , that I last saw the deceased alive on <u>JUNE 17</u> , 19 <u>59</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES S. STANTON MD</u>				DATE SIGNED <u>509 Viers Mill Rd. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park..</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7043

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>13 Carver Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elizebeth</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>June</u> Day <u>6</u> , 19 <u>59</u> Year <u>19</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1918</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William L. Hayward</u>			14. MOTHER'S MAIDEN NAME <u>Nettie C. ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>218-20-2077</u>		17. INFORMANT <u>Theodore Williams (husband)</u> Address <u>Ite m 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lacerations of Heart and Great Vessels</u> <u>823X</u> DUE TO <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Automobile Accident</u> (b) <u>Crushed Chest</u> (c) <u>Automobile Accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u> <u>Inst.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which left highway & s truck tree</u>			
20c. TIME OF INJURY Month, Day, Year <u>1:55</u> <u>30</u> <u>p. m.</u> <u>6/6/59</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>	
		20f. (City or town) <u>Cabin John</u>		(County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	
				22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>			ADDRESS <u>Rockville, Md.</u>		
24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH HOME		ALL TISSUE NONE	
NAME OF DECEASED JOHN DOE		SEX MALE	
DATE OF DEATH JAN 15 1964		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		AGE 45	
OCCUPATION CLERK		MARITAL STATUS SINGLE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF WITNESS [Signature]	
PRINTED NAME OF EXAMINER JOHN A. SMITH		PRINTED NAME OF WITNESS JANE DOE	
ADDRESS OF EXAMINER 123 MAIN ST, BALTIMORE, MD		ADDRESS OF WITNESS 456 E. ST, BALTIMORE, MD	
TELEPHONE OF EXAMINER 555-1234		TELEPHONE OF WITNESS 555-5678	
SPECIAL INSTRUCTIONS NONE		REMARKS DECEASED WAS FOUND DEAD IN HIS HOME. NO SUICIDE OR ACCIDENT.	

THIS CERTIFICATE IS VALID FOR THE STATE OF MARYLAND ONLY. IT IS NOT VALID FOR OTHER STATES OR COUNTRIES.

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TO HOSPITAL OR A FUNDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7044 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07034

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 99 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DELETED Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3515 Hillsmere Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Margaret Middle WILSON Last WILSON		4. DATE OF DEATH Month June Day 20 Year 1959					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-01	9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert BAXTER			14. MOTHER'S MAIDEN NAME Margaret MUNN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT (S) Major Alexander Wilson, USMC, same as #2			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon & cecum 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 14 mos.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to June 20 , 19 59 , that I last saw the deceased alive on June 19 , 19 59 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 6-20-59 ACTUAL SIGNATURE Burt C. Johnson M.D. PHYSICIAN'S NAME (Type) Burt C. JOHNSON, LCDR, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 6-22-59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Whittier California	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers ADDRESS 8728 Liberty Rd., Randallstown, Md.				24a. REC'D BY REGISTRAR DATE JUN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

DEPARTMENT OF HEALTH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

7045

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2012 Grosnell st</u>			d. STREET ADDRESS <u>12012 Grosnell st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret Lane Wycoski</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1923</u>		9. AGE (In years last birthday) <u>35</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>John H Staples</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Marders</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Jos. Wycoski - Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of cervix with metastases</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>13 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-23-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		(State) <u></u>		24a. REC'D BY REGISTRAR <u>JUN 25 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>	
<u>Raymond A. Ziska, Mgr.</u>		<u>Silver Spring, Md.</u>		<u></u>	

FOR STATE
HEALTH DEPT

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 15 1900</i>
AGE <i>45</i>		SEX <i>Male</i>
RACE <i>White</i>		RELIGION <i>Methodist</i>
BIRTHPLACE <i>England</i>		RESIDENCE <i>123 Main St Baltimore</i>
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>
MANNER OF DEATH <i>Natural</i>		PLACE OF DEATH <i>Home</i>
SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>		DATE <i>Jan 15 1900</i>
SIGNATURE OF NEXT OF KIN <i>John Doe</i>		DATE <i>Jan 15 1900</i>
SIGNATURE OF CLERK <i>Wm. H. Jones</i>		DATE <i>Jan 15 1900</i>



TO BE FILED IN THE
OFFICE OF THE
STATE ARCHIVES
BALTIMORE, MARYLAND

7046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
c. LENGTH OF STAY IN 1b 6 MONTHS				d. STREET ADDRESS 8804 BRADFORD ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8804 BRADFORD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCES Middle ZANET Last ZANET				4. DATE OF DEATH Month 6 Day 6 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-81	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY DRESS MAKER		11. BIRTHPLACE (State or foreign country) AUSTRIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME JOHN SAYEK			
14. MOTHER'S MAIDEN NAME MARY --*--?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT MISS ESTELE LORRAINE (SAME AS #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease (c) Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BEYONNE				20g. (County) N. J.		20h. (State) N. J.	
21. I certify that I attended the deceased from 8 May 1959 to 6 June 1959 , that I last saw the deceased alive on 6 June 1959 , and that death occurred at 8:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1011 UNIV. BLVD E SILVER SPRING DATE SIGNED 2nd							
ACTUAL SIGNATURE Thomas P Fogarty M.D.							
PHYSICIAN'S NAME (Type) THOMAS P FOGARTY							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6-7-59		22c. NAME OF CEMETERY OR CREMATORY BEYONNE		22d. LOCATION (City, town, or county) (State) N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS WASH. D.C. 3821 14TH. ST. N.W.				24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7047

CERTIFICATE OF DEATH

07037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Berwick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75 x -3</u> d. STREET ADDRESS <u>R. D. 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cynthia Maxine Zehner</u>		4. DATE OF DEATH Month Day Year <u>June 22, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1954</u>
9. AGE (In years lost birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vincent Zehner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(Brain Positive Coccus) Septicemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Lymphatic Leukemia</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1959</u> to <u>June 22, 1959</u> , that I last saw the deceased alive on <u>June 22, 1959</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nathan S. Taylor</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>		DATE SIGNED <u>6-22-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berwick, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUN 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED Robert A. Kennedy</p>		<p>2. SEX Male</p>	
<p>3. AGE 34 years</p>		<p>4. DATE OF BIRTH March 27, 1924</p>	
<p>5. PLACE OF BIRTH Boston, Mass.</p>		<p>6. OCCUPATION Student</p>	
<p>7. CAUSE OF DEATH Myocardial Infarction</p>		<p>8. MANNER OF DEATH Natural</p>	
<p>9. DATE OF DEATH June 10, 1958</p>		<p>10. TIME OF DEATH 11:00 AM</p>	
<p>11. PLACE OF DEATH St. Elizabeth's Hospital, Boston</p>		<p>12. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>13. SIGNATURE OF REGISTRAR [Signature]</p>		<p>14. SIGNATURE OF WITNESS [Signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7048 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 56	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 1708 REPUBLIC ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1708 REPUBLIC ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle MELVIN Last ZINS		4. DATE OF DEATH Month JUNE Day 15 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1950
9. AGE (In years last birthday) 9		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME LESTER ZINS		15. MOTHER'S MAIDEN NAME LILLIAN RINBERG	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT LESTER ZINS - 1708 REPUBLIC RD., SIL. SPG. MD.		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Birth to present			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from birth , 19 50 , to 6/15 , 19 59 , that I last saw the deceased alive on 6/15 , 19 59 , and that death occurred at 5:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Herbert D. Glick M.D. 8301 Piney Branch Rd PHYSICIAN'S NAME (Type) HERBERT D. GLICK, M.D. Silver Spring, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-17-59	
22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) HYATTSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS- 3501 14th STREET, N.W.		24a. REC'D BY REGISTRAR JUN 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

